

081310

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>TALCIE JANE KIRBY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 2 85</b>		2b. HOUR <b>835 P.M.</b>						
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 27 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SOUTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GENERAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		
13a. STATE <b>MD</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5220 4TH St. Balt. 21225</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Standridge</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie May Brock</b>				16. ADDRESS <b>21225 4th Street Balto Md</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-74-1437</b>		17. INFORMANT <b>John R. Kirby</b>		18. ADDRESS <b>5219 4th Street Balto Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASPIRATION PNEUMONIA</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBROVASCULAR ACCIDENT</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>BACTEREMIA</b>											
19a. DATE OF OPERATION <b>2/15</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PNEUMOPERITONEUM</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>3/1</b> , 19 <b>85</b> , to <b>3/2</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/2</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>J. A. Giral</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3/2/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. A. GIRALT</b>				22e. ADDRESS <b>3001 S. HANOVER BALTO. MD. 21230</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/6/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto Howard Md</b>			
24. FUNERAL DIRECTOR <b>George J. Gonce 4001 Ritchie Hgwy Balto Md</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1985</b>		25b. REGISTRAR'S SIGNATURE <b>ma Davidson</b>					





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>William Gordon Kirwan</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 2, 1985</b>		2b. HOUR MIN. <b>11:40 A.M.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 5, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Baltimore, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>118 N. Highland Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>
13a. STATE <b>Md.</b>	13b. COUNTY <b>---</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>118 N. Highland Ave. 21224.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William L. Kirwan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna --- Douch</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>213-07-5143</b>		17. INFORMANT <b>Baltimore, Md. 21224.</b> <b>Mrs. Jeanine I. Kirwan-118 N. Highland Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Lung Cancer</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 yrs</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/6</b> , 19 <b>79</b> , to <b>3/2</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>2/6</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>D. MacDonal</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/4/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. MacDonal</b>		22e. ADDRESS <b>9 S. Highland Ave</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Mar. 5, 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>John A. Moran, Inc. Funeral Home</b>		ADDRESS <b>3000 E. Baltimore St.; Balto., Md. 21224</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1985</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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March 2, 1952

White  
 Baltimore, Md.  
 U. S. A.

Baltimore  
 115 A. H. Street  
 Truck Driver  
 115 A. H. Street  
 Baltimore, Md.

Baltimore  
 115 A. H. Street  
 Truck Driver  
 115 A. H. Street  
 Baltimore, Md.

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March 2, 1952  
 Baltimore, Md.  
 U. S. A.

080083

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM KLEINBERG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03-19-85</b>		2b. HOUR <b>7:14</b> AM					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAR. 16, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE CITY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SOC. SEC. ADMN.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1702 E. BELVEDERE AVE. #21239</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HYMAN KLEINBERG</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>REGINA DEUTSCH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>115-01-0754</b>		17. INFORMANT <b>DR. DAVID KLEINBERG</b> <b>6733 DANVILLE AVE. BALTO., MD 21222</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pressumed lymphoma with pleural effusion</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARDIAC ARRHYTHMIA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Congestive heart failure</b>										
19a. DATE OF OPERATION <b>3/14/85</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Lymph node biopsy</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) <b>---</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>---</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>---</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 6, 1985</b> to <b>MARCH 19, 1985</b> , that (I) (we) lost saw the deceased alive on <b>MARCH 19, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>M. Keith Rawlings M.D.</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/19/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. KEITH RAWLINGS, M.D.</b>			22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>MAR. 15, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BNAI ISRAEL</b>		23d. LOCATION CITY OR TOWN COUNTY MARYLAND <b>BALTIMORE</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1985</b>		25b. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must be notified of date.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lillian A. KLIMA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 28, 1985</b>			2b. HOUR <b>10:40 PM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 28 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6812 Belclare Road 21222</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sylvester Marsalek</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Klicka</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>218-18-8772</b>	
17. INFORMANT <b>Vincent J. Klima</b>			ADDRESS <b>6812 Belclare Road Balto. MD 21222</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>MARCH 24, 1985</b> to <b>MARCH 28, 1985</b> that (I) (we) last saw the deceased alive on <b>MARCH 28, 1985</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.											
22b. SIGNATURE <i>Servillano L. Gungon</i>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-28-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SERVILLANO L. GUNGON</b>						22e. ADDRESS <b>100 NORTH BROADWAY 21231</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4/1/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Ht. of Jesus</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dundalk, Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> <b>7922 Wise Avenue, Dundalk, MD 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 2 - 1985</b>		25b. REGISTRAR'S SIGNATURE <i>John David - Hordell</i>			

038052



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 07764

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD L. KNIGHT			2a. DATE OF DEATH MONTH DAY YEAR 3 7 85		2b. HOUR 1 30 P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 26, 1922	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.		
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber	12b. KIND OF BUSINESS OR INDUSTRY Plumbing	
13a. STATE Md		13b. COUNTY --	13c. CITY OR TOWN Baltimore,	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4304 GrandView Avenue 21211
14. FATHER'S NAME FIRST MIDDLE LAST Fred H. Knight		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne B. Seal			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII	17. INFORMANT 223 189576	ADDRESS Catherine Knight same		
18. CAUSE OF DEATH (Enter only one cause per line 1a (a), (b), and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure, A.S.C.V.D</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic U.G.I. Bleed</u> <u>Heart M.I.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>History of Pleural TB + Chronic Smoking</u>					
19a. DATE OF OPERATION 3/2/85	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED U.G.I. Bleed	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> , 19 <u>85</u> , to <u>3/7</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/7</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Michael Villani MD</u>		DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3.7.85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL VILLANI, M.D.		22e. ADDRESS UNION MEMORIAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 03/11/85	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey, Howard Co. Md.		
24. FUNERAL DIRECTOR NAME Burgee-Henss Funeral Home, 3631 falls Rd. 21211		25a. DATE REC'D. BY REGISTRAR MAR 11 1985			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



51780

Handwritten notes and scribbles, including the word "COLLECT" and various illegible markings.

081124

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

07765

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Hattie I. Knight</b>			2a DATE OF DEATH MONTH DAY YEAR <b>3 18 85</b>			2b HOUR <b>5:15 AM</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>5 17 06</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <b>Md.</b>			13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Dundalk</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>1826 Dunmere Road 21222</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>IRA Vernon</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine MARSHALL</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-03-0538</b>		17 INFORMANT <b>Evelyn I. Pribble</b>		ADDRESS <b>1818 Dunmere Road Baltimore, MD. 21222</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Ovarian Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <b>March 9 19 85</b> , to <b>March 18 19 85</b> , that (I) (we) lost saw the deceased alive on <b>March 17 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Sorge J. Acevedo Vilá</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c DATE SIGNED <b>3/18/85</b>				
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sorge Acevedo Vilá</b>						22e ADDRESS <b>3001 S Hanover St. Baltimore Md.</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>3/21/1985</b>		23c NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>						25a DATE REC'D. BY REGISTRAR <b>MAR 20 1985</b>		25b REGISTRAR'S SIGNATURE <b>John Davidson Rondella</b>		
7922 Wise Avenue Dundalk, Maryland 21222										

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 3 PRIOR TO YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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 BP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 07166									
1- STATE REGISTRAR																					
1 DECEASED NAME (TYPE OR PRINT)						FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		7b. HOUR	
William Thomas Knox												3		22		19		85		M	
2. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male		White		10 5 22		62 YRS.						3		22		19		85		6:50P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland				U.S.A.								Baltimore City MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore				Francis Scott Key Medical Center								Baker				Food					
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland				Baltimore				Baltimore				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7148 Gough Street 21224							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME															
Ellis Knox						Ida Belle Mutte															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS													
Yes				WW II				215-18-3296				Mrs. Katina B. Knox, 7148 Gough Street Baltimore, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																					
PART I DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:																					
(b) _____																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c) _____																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
				HOUR A.M. MONTH DAY YEAR																	
				P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION													
								STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE				TITLE (SPECIFY)										DATE SIGNED							
				M.D. Assistant MEDICAL EXAMINER										3/23/85							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
Gregory R. Kauffman, M.D.				111 Penn St. Balto., MD.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
Burial				3-26-85				Oak Lawn Cemetery				Baltimore Baltimore Md.									
24. FUNERAL DIRECTOR NAME														25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Ann S. Matthews, 3021 Eastern Ave., Baltimore, Md.														MAR 27 1985				[Signature]			

MEDICAL CERTIFICATION

CHICAGO

DEPARTMENT OF COMMERCE

UNITED STATES

NAVY



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Olga		F.				Koch		XX		3-6		19		85				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Fem.	Cau.	10 23 16		68 YRS.						3-6		19		85				7:45 P. M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
Md.		U.S.A.		WIDOWED		X		Baltimore City,										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		1507 E. 36th Street						Retired											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1507 E. 36th St. 21218											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Jacob		Buettner		Julia		E. Rethschulte													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
no		215-36-8048		Richard P. Koch		6 Ranger Ct. 21234													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE <u>Dennis F. Smyth</u>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		3-7-85											
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS		111 Penn St., Balto., Md. 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		3-9-85		Dulaney Valley Cem.		Cockeysville Balto. Md.													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
John C. Miller Inc.		6415 Belair Rd.		MAR 8 1985		Julia Davidson-Randall													

82-120  
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2028 COTTON LIBER

1000 WESTERN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 0 7 / 6 8  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Charles J. Koehler		MONTH DAY YEAR 3 6 85	
2b. HOUR 2:50 P.M.			
3. SEX male		4. RACE White	
5. DATE OF BIRTH MONTH DAY YEAR March 12, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY	
13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1107 E. Belvedere Avenue		21239	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Koehler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia Kram	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW 1 213-09-4541	
17. INFORMANT ADDRESS Mr. Charles Wagner 4300 Soth Ave 21236			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-6-85, to 3-6-85, that (I) (we) last saw the deceased alive on 3-6-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Adel S. EL-Hennawy		22c. DATE SIGNED 3-6-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 9, 1985	
23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR MAR 7 1985	
25b. REGISTRAR'S SIGNATURE The Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 7 6 9

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST ROSALIE R. KOHLER		MONTH DAY YEAR 3 2 85	
3. SEX Female		4. RACE CAUC.	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MONTH DAY YEAR 1 03 04		81	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		8. CITIZEN OF WHAT COUNTRY? U. A. S.	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY		10. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Nurse	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KESLOICK		12. KIND OF BUSINESS OR INDUSTRY Nurseing	
13a. STATE Maryland		13b. CITY OR TOWN Baltimore	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 2175 Cromwell Bridge Road 21234	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Redman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Michener	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 170-22-3021	
17. INFORMANT Helen Kohler		2175 Cromwell Bridge Road Baltimore, Maryland 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspirator Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Congestive Heart Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21a. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/2/85</u> 19 <u>84</u> to <u>3/5</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3/2/85</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Philip Moore</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22c. DATE SIGNED <u>3/2/85</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip Moore, M.D.	
22e. ADDRESS 700 West 40th Street Baltimore, Md.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	
23b. DATE 3-5-85		23c. NAME OF CEMETERY OR CREMATORY New Bethel Vion Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Greenwich, Pennsylvania		24. FUNERAL DIRECTOR NAME ADDRESS Marzullo Funeral Service Reisterstown, Md.	
25a. DATE RECD. BY REGISTRAR MAR 5 1985		25b. REGISTRAR'S SIGNATURE <u>W. Davidson-Randall</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Res. 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 07770

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME FIRST MIDDLE LAST Myrtle Elizabeth Komornik		2a. DATE OF DEATH MONTH DAY YEAR 3/12/85	
3. SEX Female		2b. HOUR 950 A.M.	
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 27 1914	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH Baltimore		9. BALTIMORE CITY OR COUNTY OF DEATH B. City MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. CITY OR TOWN Dundalk	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 501 Wise Avenue 21222	
4. FATHER'S NAME FIRST MIDDLE LAST Byron Kling		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence E. McClelland	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-24-0362	
17. INFORMANT ADDRESS Laura A. Stewart		Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MI</u> (c) <u>CVA</u>			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4d 7			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 3/8 1985, to 3/12/85, to 3/12/85, that (1) (we) last saw the deceased alive on 3/11/85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Evan S. Samett MD		22c. DATE SIGNED 3/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVAN S. Samett		22e. ADDRESS FSCMC 4940 East Ave, Baltimore 21222	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/15/1985	
23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR Duda-Ruck, Inc. NAME ADDRESS 7922 Wise Avenue Dundalk, MD. 21222		25a. DATE REC'D. BY REGISTRAR MAR 14 1985	
25b. REGISTRAR'S SIGNATURE Lena Davidson-Rodell			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Carl F. Kosmicky</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 13 1985</b>		2b. HOUR <b>3 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 16 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <b>4306 Plainfield Ave.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Factory Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Crown, Cork &amp; Seal</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>4306 Plainfield Ave. 21206</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Kosmicky</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Veronica Agramski</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW II</b>		16b. SOCIAL SECURITY NO. <b>215-01-6054</b>		17. INFORMANT ADDRESS <b>Mary Kosmicky (wife) same address</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A.S.C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Walter R. Welzant, MD</b> DEGREE for Morton Orman, M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/15/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Walter R. Welzant</b>		22e. ADDRESS <b>Medical Arts Bldg. Room 422</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/16/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Schimunek Funeral Home, Inc.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 15 1985</b>		
25b. ADDRESS <b>3331 Brehms Lane Balto. Md. 21213</b>			25c. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

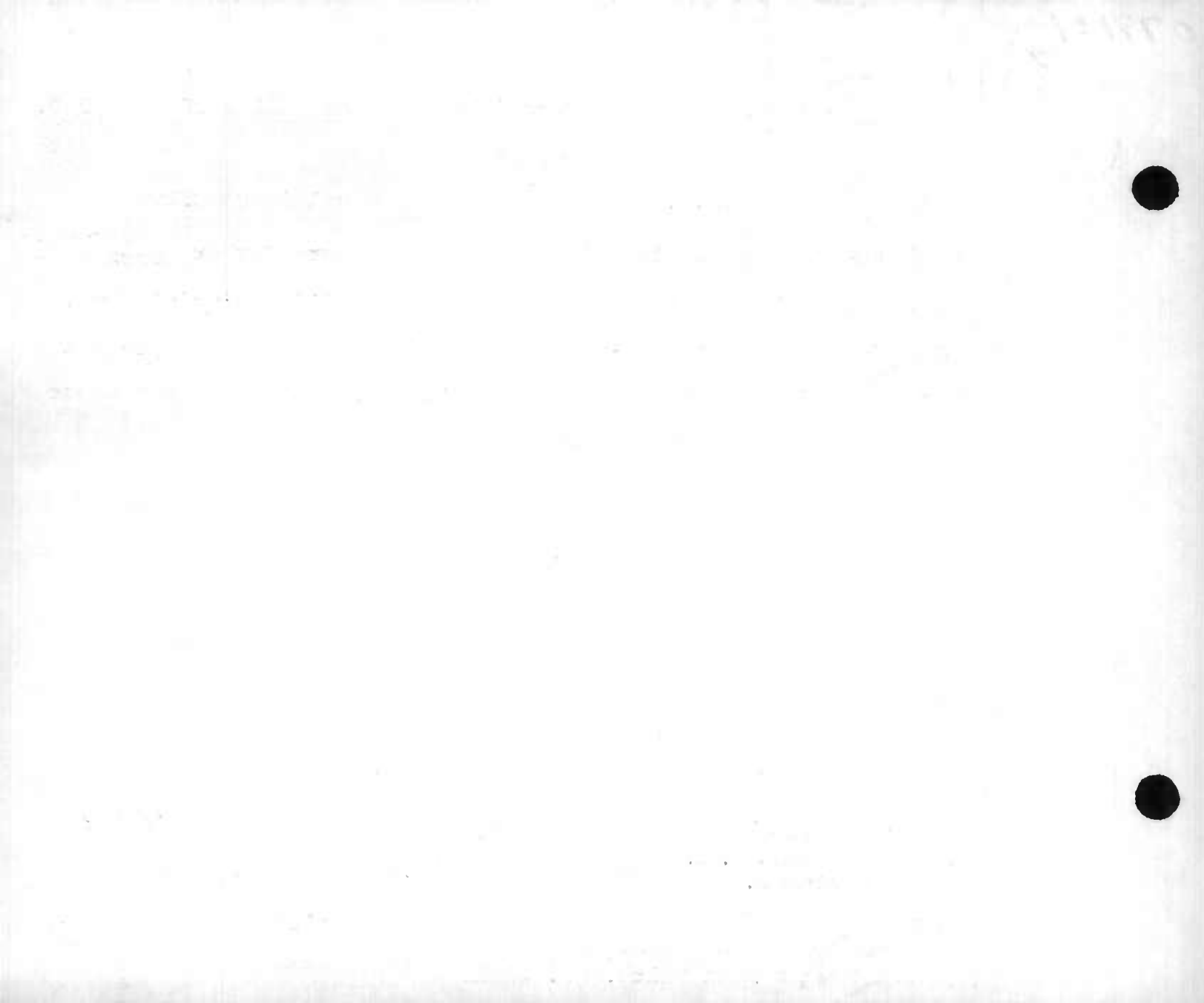
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
CHRISTIAN S. KOTSCHENREUTHER								MAR. 25, 1985								2:10 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
MALE		WHITE		MAY 3 1911		73		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
GERMANY		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE CITY										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
BALTIMORE		JOHNS HOPKINS HOSPITAL		BREWER		BREWERY											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
MD.				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4365 SHELDON AVE. 21206									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
JOHN		EVA															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		215-03-7640		MARIE KOTSCHENREUTHER (WIFE)		SAME ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u>		DUE TO, OR AS A CONSEQUENCE OF (b) <u>RIGHT MIDDLE CEREBRAL ARTERY ANEURYSM</u>		DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 YEARS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>19</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> , 19 <u>85</u> , to <u>3/25</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/25</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Meat Hunter</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/25/85</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
BURIAL		3/28/85		Parkwood Cem.		Baltimore											
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Schimunek Funeral Home, Inc.		3331 Brehms Lane Balto. Md. 21218		MAR 26 1985													

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in the funeral director's office. It should be attached for use as the burial-transit permit. Then please remove carbon copies, return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any other traumatic event, the death certificate will be referred to the Medical Examiner.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 85 07773	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>John Francis Krein</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>03-12-85</i>		2b. HOUR M			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>07-31-1910</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>74</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County, City MD.</i>					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>6401 Loch Raven Blvd. Apt. 646</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Salesman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i>			
13a. STATE <i>MD</i>		13b. COUNTY <i>City Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>6401 Loch Raven Blvd. Apt. 646 Zip 21239</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jerome Krein</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katherine Schmeltzer</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>215032253</i>		17. INFORMANT ADDRESS <i>George J. Krein 14959 Old Frederick Rd. Woodbine, MD</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial Infarction (As described with medical examiner)</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate Interval Between Onset and Death <i>Sudden</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Ischemic Congestive Cardiomyopathy &amp; Congestive Heart Failure Old myocardial infarction</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> 19 <i>74</i> to <i>March</i> 19 <i>85</i> , that <del>the</del> (we) last saw the deceased alive on _____ 19 _____, and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Herman Brecher M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>3/19/85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Herman Brecher, M.D.</i>				22e. ADDRESS <i>6410 Windsor Mill Rd 21207</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-14-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lake View Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Eldersburg Carroll MD</i>					
24. FUNERAL DIRECTOR NAME <i>Harry W. Haight</i>				ADDRESS <i>Sykesville, MD</i>		25. DATE REC'D. BY REGISTRAR <i>MAR 15 1985</i>					

MEDICAL CERTIFICATION

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*Journal of Management Education* 30(6)

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## Discussion

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>Kathryn Perkins Kriel</b>					2a. DATE OF DEATH MONTH <b>3</b> DAY <b>7</b> YEAR <b>1985</b>		2b. HOUR <b>6:35</b> A.M.		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>May</b> DAY <b>15</b> YEAR <b>1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W.Va</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>203 Ridgemed Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b></b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST <b>Earl</b> MIDDLE <b>G</b> LAST <b>Perkins</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Edna</b> MIDDLE <b></b> LAST <b>Runyan</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>214 38 0724</b>		17. INFORMANT ADDRESS <b>Harry G. Kriel Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Bladder Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b></b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from <b>11/15</b> , 19 <b>82</b> , to <b>3/7</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>2/25</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Davis M Hahn</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/7/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Davis M Hahn</b>				22e. ADDRESS <b>5601 Loch Raven Blvd 21239</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/9/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Md</b>		23e. NAME OF REGISTRAR <b>13 1985</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b>				ADDRESS <b>6500 York Rd.</b>					

2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818 2819 2820 2821 2822 2823 2824 2825 2826 2827 2828 2829 2830 2831 2832 2833 2834 2835

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BLANCHE KRIVISKY</b>		2a. DATE OF DEATH MONTH <b>03-13-85</b> DAY <b>13</b> YEAR <b>1985</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>	
5. DATE OF BIRTH MONTH <b>5</b> DAY <b>15</b> YEAR <b>1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO. MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. MD. CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTO. MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVINDALE HEBREW CENTER CARE DEPT</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS)		12b. KIND OF BUSINESS OR INDUSTRY <b>FOODS</b>	
13a. STREET ADDRESS / ZIP CODE <b>4950 OLD CT. RD. #21133</b>		13b. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME FIRST <b>OSCAR</b> MIDDLE LAST <b>KATZEN</b>		15. MOTHER'S MAIDEN NAME FIRST <b>REBECCA</b> MIDDLE LAST <b>KARLOFF</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-16-9831</b>	
17. INFORMANT <b>MR. LEONARD KRIVISKY</b>		18. ADDRESS <b>7202 ROCKLAND HILLS DR. BALTO., MD 21209</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>OF THE BREAST</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS.</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>03-06-85</b> 19 <b>85</b> , to <b>03-13-85</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>03-13-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>B. ZAW-LWIN, MD</b> DEGREE		22c. DATE SIGNED <b>03-13-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. ZAW-LWIN, MD</b>		22e. ADDRESS <b>LEVINDALE HEBREW CENTER BALTO 21215</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MAR. 15, 1985</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ANSHE EMUNAH</b>		23d. LOCATION <b>BALTIMORE</b> COUNTY <b>MARYLAND</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. REGISTRAR'S SIGNATURE	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

5 07776

1 DECEASED NAME (TYPE OR PRINT) <b>Stephen Kuchta</b>		2a DATE OF DEATH MONTH DAY YEAR <b>3 15 1985</b>		2b HOUR <b>M</b>	
3 SEX <b>Male</b>	4 RACE <b>Cauc.</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>12 22 1895</b>	6 AGE (IN YEARS LAST BIRTHDAY) YRS <b>89</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Med. Cen.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Die Setter</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Canning</b>	
13a. STATE <b>Md.</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>104 N. Glover St. 21224</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Kuchta</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anastasia Kes</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>215-07-5978</b>		17 INFORMANT ADDRESS <b>Francis Kuchta 1631 Hardwick Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Coronary Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Compulsive Heart Failure, Atrial Fibrillation.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.					
22b. SIGNATURE <i>Michael H. [Signature]</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-15-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/18/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>B. Dabrowski &amp; Son 2818 E. Baltimore St</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Carrie C. Kupstas			2a. DATE OF DEATH MONTH DAY YEAR 03 30 85			2b. HOUR 9:35 P.M.			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 03 15 85		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 15 8 16		IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MED. CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Crofton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1618 English Place	
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Kupstas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne O'Brien					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT Charles Kupstas		ADDRESS 1618 English Place Crofton, MD 21114			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RESPIRATORY DISTRESS SYNDROME</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>TRISOMY 18</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>PREMATURITY</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from <u>3/15/85</u> 19 <u>85</u> , to <u>3/30/85</u> 19 <u>85</u> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Salvador PAPA</u>				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/30/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SALVADOR PAPA, MD				22e. ADDRESS FRANCIS SCOTT KEY MED CENTER.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-2-85		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ortanna Adams PA			
24. FUNERAL DIRECTOR <u>Robert Monahan</u>				ADDRESS Gettysburg, PA		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>APR 03 1985</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3), should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(A1)

078006

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5  
CERTIFICATE OF DEATH

07778

1. DECEASED NAME (TYPE OR PRINT)		FIRST MARGARET	MIDDLE C.	LAST KWEDAR	2a. DATE OF DEATH MONTH DAY YEAR 3-14-85		2b. HOUR 7:35 pm	
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-7-1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hair Dresser		12b. KIND OF BUSINESS OR INDUSTRY Self Employed
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Martin Kwedar		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Magdalena Kasinskas		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				
16b. SOCIAL SECURITY NO. 215-32-5027		17. INFORMANT ADDRESS Mrs. Ann C. Crane 6007 Eurith Ave. 21206						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Ischemic cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3 years 3 years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Aspiration of tooth</u>								
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3-5</u> 19 <u>85</u> to <u>3-14</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3-14</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Mary M. Newman</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V Mary M. Newman, M.D.		22e. ADDRESS Union Memorial Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 3-18-85		23c. NAME OF CEMETERY OR CREMATORY Holy REdeemer Cem.		23d. LOCATION BALTO. COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc-6415 Belair Rd.				25a. DATE REC'D. BY REGISTRAR MAR 18 1985		25b. REGISTRAR'S SIGNATURE <u>Wanda M. Gordon</u>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Bill R. Lambert			2a. DATE OF DEATH MONTH DAY YEAR 3 31 85		2b. HOUR 9:22 PM
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 2 23 25	6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY MASS TRANSIT
13a. STATE Maryland			13b. COUNTY BALTO	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST EVERETT - LAMBERT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL -		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WVI 245-22-1810	17. INFORMANT ADDRESS - PASADENA, MO. PAMELA LAMBERT - 1964 TOPLAR RIDGE RD.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Chronic Renal Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/11/85 to 3/31/85, that (I) (we) lost saw the deceased alive on 3/31/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) did not see the body after death.					
22b. SIGNATURE Clifford L. Amend		DEGREE MD		22c. DATE SIGNED 3/31/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clifford L. Amend		22e. ADDRESS Sinai Hospital Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4/3/85	23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE V.A.		23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDEL MD	
24. FUNERAL DIRECTOR NAME WAITER DABROWSKI - 1005 DUNDALK AV.		APR 04 1985		25b. REGISTRAR'S SIGNATURE Julia Swickard Arnold	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 / 8 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LILLIAN</b> <b>LAMBERT.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 02 85</b>			2b. HOUR <b>0700 AM</b>					
3. SEX <b>F</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-4-1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balto. City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John C. DEATON Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HomeMaker</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto. City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5511 Bowleys Lane 21213</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles H. Willis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Isabella M. Sunstrum</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-22-7164</b>		17. INFORMANT ADDRESS <b>Irwin J. Meyer, 4501 Teeder Road</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>stroke</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypertension</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>many years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Atherosclerotic cardiovascular disease</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 13</b> 19 <b>83</b> , to <b>Mar 2</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>Mar 2</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Ron Wish MD</b>						22c. DATE SIGNED <b>3/2/85</b>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ron Wish</b>		
22e. ADDRESS <b>Deaton Med Center Balt, Md</b>											
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>			23b. DATE <b>3-5-85</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Balto. MD</b>		
24. FUNERAL DIRECTOR NAME <b>John C. Miller, Inc., 6415 Belair Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1985</b>			25b. REGISTRAR'S SIGNATURE <b>Gutha Davidson-Randall</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Margaret E. Lancaster</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/ 17/1985</b>			2b. HOUR M <b>M</b>				
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 14 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2231 Garrison Blvd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Lee</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gilly Barnes</b>			13e. STREET ADDRESS / ZIP CODE <b>1610 Lorman Ct. Baltimore, Maryland 21217</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>			16b. SOCIAL SECURITY NO. <b>220-30-0833</b>		17. INFORMANT ADDRESS <b>Charles Lancaster 5107 Pall Mall Road Baltimore, Md. 21215</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer of the uterus, Metastasised to abdomen and chest wall.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cancer</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypertension</b>										
19a. DATE OF OPERATION <b>12-5-83</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Satisfactory</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>October 19 80</b> to <b>January 19 85</b> , that (I) (we) lost saw the deceased alive on <b>November 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Alphonso Y. S. Rhee, M.D.</b>			DEGREE			22c. DATE SIGNED <b>3-19-85</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alphonso Y. S. Rhee, M.D.</b>			22e. ADDRESS <b>449 East 25th Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/21/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Star Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL HOME OR NAME ADDRESS <b>Nutter &amp; Sons 2501 Gwynns Falls Parkway Baltimore, Inc. Baltimore, Maryland 21216</b>			25. DATE REC'D. BY REGISTRAR <b>MAR 20 1985</b>			25. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>				

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SAITOMOTO, Y.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

07/82

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ALFRED COOKMAN LANE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 13, 1985</b>		2b. HOUR <b>7:30A M</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 7, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>21204</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8618 PLEASANT PLAINS ROAD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>REPAIRMAN</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>TELEVISION</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>21204</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>CLIFTON LANE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>RUTH LEACH</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>WW II</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>YES 214-14-5653</b>		17. INFORMANT ADDRESS <b>JULIA M. LANE 8618 PLEASANT PLAINS RD. 21204</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetes mellitus &amp; multiple complications</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive or (above, placed) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John H. Stone, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN H. STONE, M.D.</b>		22e. ADDRESS <b>615 HAMMONDS LANE 21225 636-6886</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>MARCH 14, '85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MARYLAND</b>		23e. DATE REC'D BY REGISTRAR <b>MAR 15 1985</b>			
24. FUNERAL DIRECTOR NAME <b>WILLIAM E. JOHNSON</b>		ADDRESS <b>8521 LOCH RAVEN BLVD.</b>		25. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

115970

AGENCY: [illegible] DATE: [illegible]  
SUBJECT: [illegible]  
[illegible text]

200 COLIBIA LIBER

[illegible text]

REMARKS: [illegible]  
[illegible text]

087048

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST John			MIDDLE Stanley			LAST (Laniewski) Lane			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3-21 1985			2b. HOUR 9:50				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 04 05 08		6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS.		7. IF UNDER 24 YRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 3-21 1985			2d. HOUR a.50						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital - DOA				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer				12b. KIND OF BUSINESS OR INDUSTRY Civil Service							
13a. STATE Maryland				13b. CITY OR TOWN ---				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 1708 Wilmington Avenue, 21230			
14. FATHER'S NAME FIRST MIDDLE LAST John Laniewski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Filipiak				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW II 213-07-9294				17. INFORMANT ADDRESS Frances Lane 1708 Wilmington Avenue 21230			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Dennis F. Smyth, M.D.				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 3-21-85											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 03-25-85				23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk. A.A. Maryland							
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				ADDRESS 21229				25a. DATE REC'D. BY REGISTRAR 3-27-85				25b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION



204 COMD 111111

31 JAN 71 W 111111



092101

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 / 8 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PAULINE Mae LANE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3/27/85</b>		2b. HOUR <b>7:40 A</b>	
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 12 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital of Md</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Thomas</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa Waters</b>		13e. STREET ADDRESS / ZIP CODE <b>3625 W. Lexington St. Baltimore, Maryland 21229</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>	16b. SOCIAL SECURITY NO. <b>212-36-3504A</b>	17. INFORMANT <b>Irene Thomas</b> ADDRESS <b>3625 W. Lexington Street Baltimore, Maryland 21216</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. [Signature]</b>		DEGREE		22c. DATE SIGNED <b>3/27/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEONINA L. CHEFO</b>		22e. ADDRESS <b>LUTHERAN HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>4/1/1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cen.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Nutter &amp; Sons 2501 Gwynns Falls Parkway Funeral Home, Inc. Baltimore, Maryland 21216</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 29 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

000102

Baltimore City

U. S. A.

Maryland

Postoffice

Postoffice

3655 E. Washington  
Apt. 2nd Fl.

St. Baltimore, Maryland 21202

Baltimore

Maryland

3655 E. Washington  
Apt. 2nd Fl.  
Baltimore, Maryland 21202

Baltimore

Maryland

No.

100-36-100A

100-36-100A

100-36-100A

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100-36-100A

088114

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, a medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ALBERT J. LANG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 21 85</b>		2b. HOUR 3:24 PM	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 23 1915</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Medical Center</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Optical Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hilber Co.</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alphonse J. Lang</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes M. Rohde</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-05-3536</b>		17. INFORMANT <b>Jean Humphreys</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>RESPIRATORY FAILURE</b>		DUE TO, OR AS A CONSEQUENCE OF (c) <b>PNEUMONIA</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>S/P Pneumococcal for TB, COPD, Crohn's Dis., ankylosing spondylitis</b>						
19a. DATE OF OPERATION <b>3/13/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PROLONGED INTUBATION</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>3/14/85</b> , 19 <b>85</b> , to <b>3/21</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/21</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Michael Sullen</b>		DEGREE		22c. DATE SIGNED <b>3/21/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SULLEN</b>		22e. ADDRESS <b>Francis Scott Key Med Ctr</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3/25/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>		
23d. LOCATION CITY OR TOWN <b>Baltimore</b>		COUNTY <b>Maryland</b>		STATE		
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>		ADDRESS <b>7922 Wise Avenue Dundalk, Maryland 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>		
				25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>		



084119



DMO

DMO

13317

2855

03 x 2 34

081317

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 7 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>James A. LANGELLOTO</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>7</b> YEAR <b>85</b>			2b. HOUR <b>4</b> MIN <b>28</b> AM			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Dec.</b> DAY <b>18</b> YEAR <b>1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital, Balto. Md.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self employed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>			
14. FATHER'S NAME FIRST <b>Ferdinand</b> MIDDLE <b>---</b> LAST <b>Langellotto</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Philonina</b> MIDDLE <b>---</b> LAST <b>Saccinto</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-01-1624 A</b>		17. INFORMANT ADDRESS <b>Mrs. Catherine L. Langellotto, Same as above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cordine Arrest -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart Failure - Ventricular Tachycardia - Atrial Fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterial Valve Regurgitation</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>2/13/85</b> , 19____, to <b>3/7/85</b> , 19____, that (I) (we) last saw the deceased alive on <b>3/6/85</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
23a. SIGNATURE <b>Michael F. Plott, MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/7/85</b>	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL F. PLOTT, MD</b>						22e. ADDRESS <b>Mercy Hosp Balto, Md 21202</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Mar. 11, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore,</b> COUNTY <b>Maryland</b> STATE		
24. FUNERAL DIRECTOR NAME <b>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</b> ADDRESS <b>21230</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 8 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Janie m. Langford</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>31</b> YEAR <b>85</b>			2b. HOUR <b>6:43 PM</b>				
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>7</b> YEAR <b>1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5137 Pembridge 21215</b>	
14. FATHER'S NAME FIRST <b>David</b> MIDDLE <b>Maynor</b> LAST <b>Mattie</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mattie</b> MIDDLE <b>Maynor</b> LAST <b>Mattie</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-20-7547</b>		17. INFORMANT <b>David K. Brown</b>				ADDRESS <b>5137 Pembridge Ave. MD 21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/30, 1985</b> , to <b>3/31, 1985</b> , that (I) (we) last saw the deceased alive on <b>3/31, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Clifford L. Amend</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/31/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Clifford L. Amend</b>			22e. ADDRESS <b>Sinai Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4-4-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garden of Eternal Hope Westminster</b>		23d. LOCATION CITY OR TOWN <b>Westminster</b> COUNTY <b>Maryland</b> STATE <b>Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>The Bailey - Douglass Funeral Home</b> ADDRESS <b>1348 North Calhoun</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 03 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LOUISE V. LAWSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-4-85</b>			2b. HOUR M			
3. SEX <b>FEMALE</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-20-15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>T. J. CHAINEY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BLANCHE WATKINS</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>218-18-6390</b>			17. INFORMANT ADDRESS <b>Elayna Stewart 6113 Maylane Dr.</b>						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF: (b) <b>ASHD / SEPSIS</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <b>- DIABETES / RENAL FAILURE</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 19 83</b> to <b>MAR 19 85</b> that (I) (we) last saw the deceased alive on <b>4 MAR 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>CHRIS EDAW</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHRIS EDAW</b>		22e. ADDRESS <b>1940 W BALTIMORE</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/9/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MD, Nat'l Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March E/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 6 1985</b>	
				25b. REGISTRAR'S SIGNATURE <b>Gina Gordon-Hopkins</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST HENRY	MIDDLE A.	LAST LAZOWSKI	2a. DATE OF DEATH		MONTH Mar	DAY 13	YEAR 85	2b. HOUR 11 <sup>30</sup>	AM
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
				MONTH 10 DAY 26 YEAR 1922		62 YRS.		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) YORK, PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD					
10. CITY OR TOWN OF DEATH BALTO. CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY HOSPT.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RAILROAD WORKER		12b. KIND OF BUSINESS OR INDUSTRY BETH. STEEL			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD.		13b. COUNTY BALTO. CO.		13c. CITY OR TOWN PARKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3314 WOODSIDE AVE 21234			

4 FATHER'S NAME FIRST JULIAN MIDDLE LAST LAZOWSKI		15 MOTHER'S MAIDEN NAME FIRST MARY MIDDLE RZEWNICKA LAST	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO. (YES, NO OR UNKNOWN)	17 INFORMANT ADDRESS MARY ELLEN LAZOWSKI PARKVILLE, MD.	
YES NO OR UNKNOWN	YES NO OR UNKNOWN	3314 WOODSIDE AVE	
W.W. II	212.16.8055		

<b>18. CAUSE OF DEATH</b> (Enter only one cause primary for report on this form) <b>PART I. DEATH WAS CAUSED BY:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<b>IMMEDIATE CAUSE (a)</b> <u>Acute Myocardial Infarction</u>		
Conditions, if any, which gave rise to immediate cause: (a) stating the underlying cause last.	<b>DUE TO OR AS A CONSEQUENCE OF</b>	
	<b>(b)</b> <u>Arteriosclerotic Cardiovascular Disease</u>	
	<b>DUE TO OR AS A CONSEQUENCE OF</b>	
	<b>(a)</b>	

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (100)

1% DATE OF OPERATION				1% CONDITION FOR WHICH OPERATION WAS PERFORMED				70% AUTOPSY				70% IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
—				—				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
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MEDICAL	714. INJURY OCCURRED	716. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	717. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
	WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					

72a. I certify that (I) (this hospital) attended the deceased from 2/18/81 to 2/19/81 that (I) (we) last saw the deceased alive on 2/18/81 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (we) (do) (do not) see the body after death.

72b. SIGNATURE <i>W. Kasik, Jr.</i>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	72c. DATE SIGNED <b>3/14/85</b>
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22a PHYSICIAN'S NAME (TYPE OR PRINT)	22b ADDRESS
DR. FRANK KASIK JR.	9005 HARFORD RD. PARKVILLE, MD

23a. BURIAL, <u>CREMATION</u> , REMOVAL (SPECIFY) <u>CREMATION</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEM.</u>	23d. LOCATION CITY OR TOWN <u>BALTO. CITY</u> COUNTY STATE <u>Md.</u>
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24 FUNERAL DIRECTOR	8800 HARFORD RD. DARKVILLE, MD. 21234	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
EVANS FUNERAL CHAPEL		MAR 19 1985	Gale Davidson-Pandell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



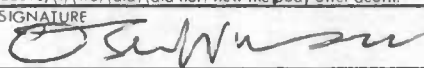

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

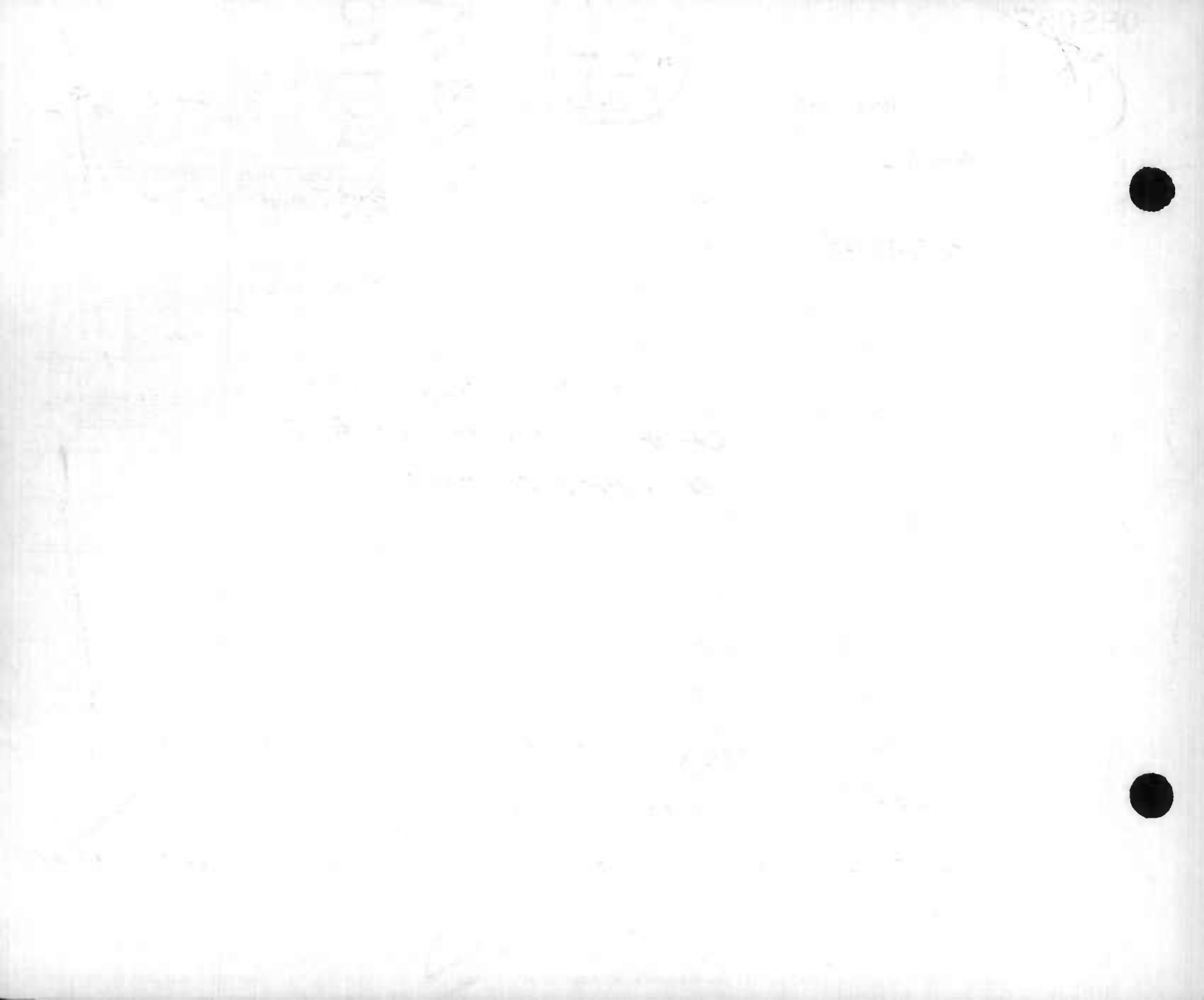
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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHRISTINE LED BETTER</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>24</b> YEAR <b>85</b> 6:55 <b>A</b> M		
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>20</b> YEAR <b>27</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.	7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13a. STATE <b>MD</b>	13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13e. STREET ADDRESS / ZIP CODE <b>2946 Garrison Blvd. 21215</b>		
14. FATHER'S NAME FIRST <b>Wilbert</b> MIDDLE <b>Broadway</b> LAST			15. MOTHER'S MAIDEN NAME FIRST <b>Emma</b> MIDDLE <b>McLendon</b> LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-44-2778</b>	17. INFORMANT ADDRESS <b>Genet Smith 8242 Church Lane</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRONCHIAL ASTHMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/20</b> 19 <b>85</b> , to <b>3/24</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/23</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A-OSEI-WUSU MD</b>		22e. ADDRESS <b>5710 WABASH AVE. BALT. MD 21215</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/29/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>	23d. LOCATION <b>Baltimore Co. MD</b> STATE		
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b> REGISTRAR'S SIGNATURE 		

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091122

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	07791	
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Carnell (Lee) Lee (Carnell)</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>3/</b> DAY <b>25/</b> YEAR <b>1985</b>		2b. HOUR <b>11:22</b> M <b>P</b>
3 SEX <b>male</b>	4 RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>2</b> YEAR <b>52</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>32</b> YRS.	IF UNDER 1 YR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	2c. DATE PRONOUNCED DEAD <b>3/ 25/ 19 85</b>		2d. HOUR <b>11:22</b> M <b>P</b>						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD								
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE <b>Maryland</b>		13b. COUNTY <b></b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1527 East 29th St. 21218</b>						
14. FATHER'S NAME FIRST <b>Essie</b> MIDDLE <b></b> LAST <b>Lee</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b></b> LAST <b>McDuffie</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b></b>		17. INFORMANT ADDRESS <b>Mary McDuffie 1527 East 29th St.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Alcoholism</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <b>[Signature]</b>				TITLE (SPECIFY) <b>M.D. Assistant</b>				MEDICAL EXAMINER		DATE SIGNED <b>3/26/85</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>				ADDRESS <b>111 Penn St.</b>										
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3/30/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>				23d. LOCATION <b>Baltimore,</b> COUNTY <b></b> STATE <b>Md.</b>						
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b> ADDRESS <b>1101 E North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1985</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>						

251100



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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 0 7 7 9 2  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Qu: DA C Lee			2a. DATE OF DEATH MONTH DAY YEAR 3 15 85		2b. HOUR 4:40AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8 26 53		6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	
12b. KIND OF BUSINESS OR INDUSTRY School		13a. STREET ADDRESS / ZIP CODE 1514 N Pulaski St BALTO, MD. 21217		13b. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Henry H Lee		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTELLE Bell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 218-50-5720		17. INFORMANT MR. HENRY H. LEE		ADDRESS 514 N. PULASKI STREET BALTIMORE, MD. 21217	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN STEM Compression DUE TO, OR AS A CONSEQUENCE OF (b) Malignant BRAIN Tumor DUE TO, OR AS A CONSEQUENCE OF (c) 1979					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2 25 19 85, to 3 15 19 85 that (I) (we) last saw the deceased alive on 3-14 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) not view the body after death.					
22b. SIGNATURE Henry Elser MD		DEGREE MD		22c. DATE SIGNED 5-15-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry Elser		22e. ADDRESS 22 S. Greene St. Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/20/1985		23c. NAME OF CEMETERY OR CREMATORY MD, NAT. MEM. PK.	
23d. LOCATION CITY OR TOWN LAUREL		COUNTY MO.		STATE	
24. FUNERAL DIRECTOR NUTTER & SONS 2501 GWYNNS FALLS PKWY. FUNERAL HOME, INC. BALTIMORE, MD. 21216		25a. DATE REC'D. BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 7 9 3

1- FOR  
STATE REGISTRAR ROSE S. LEEF

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose S. LEEF			2a. DATE OF DEATH MONTH DAY YEAR 3-7-85			2b. HOUR 11:50A M										
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 15, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD										
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Receptionist		12b. KIND OF BUSINESS OR INDUSTRY Slaysman Co.								
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland									13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 918 Vanderwood Road 21228	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Schwatka			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose P. Travers													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-14-6941A			17. INFORMANT Lewid B. Leef			ADDRESS Same as # 13							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Bronchogenic Carcinoma

DUE TO, OR AS A CONSEQUENCE OF

(c)

Pneumonia

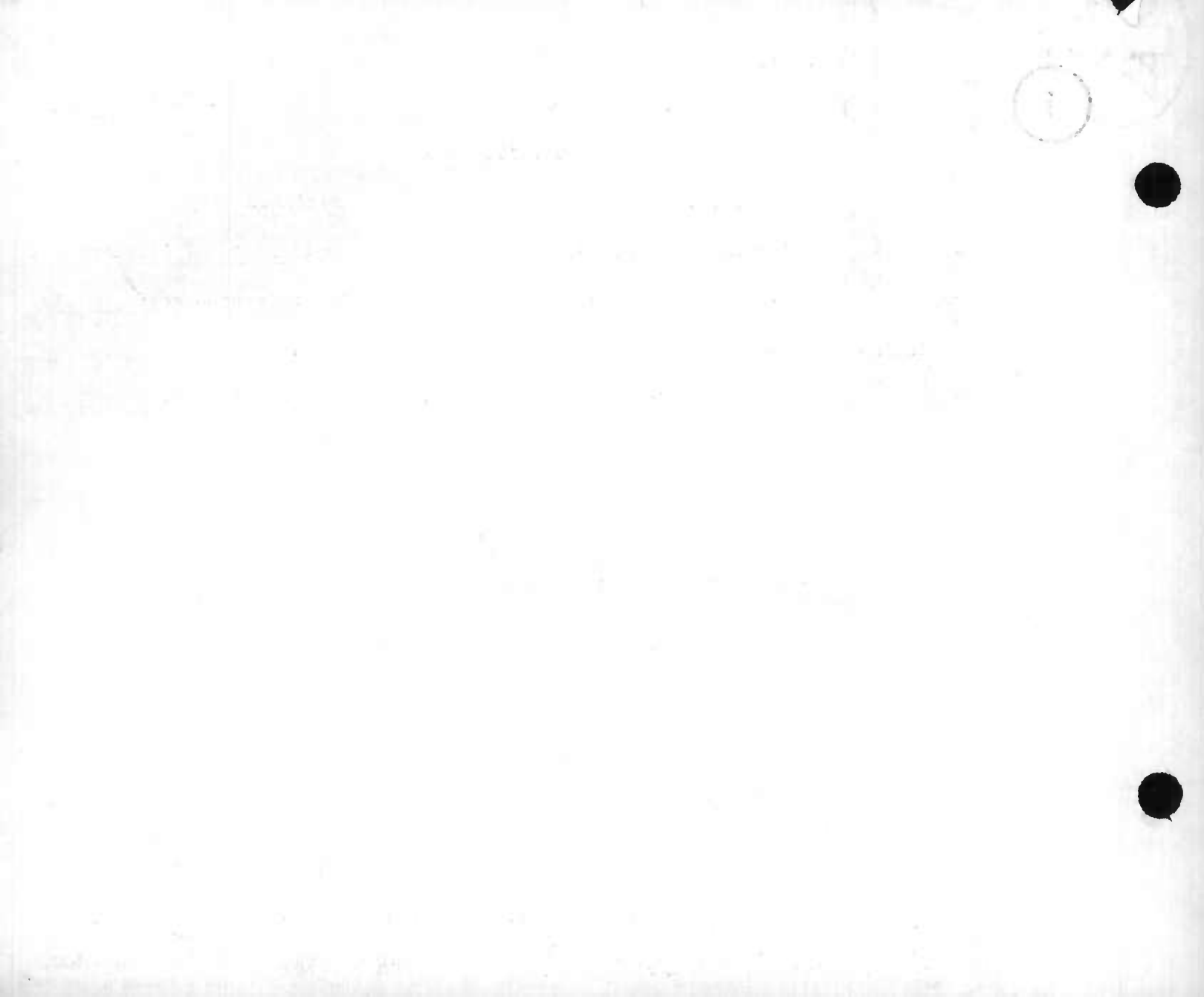
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Congestive heart failure

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-13-85 to 3-7-85, that (I) (we) last saw the deceased alive on 3-7-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE Attending Physician				22c. DATE SIGNED 3-7-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DARSHAN S. SALUJA MD				22e. ADDRESS 1600 MT Royal Ave, Baltimore 21217			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/11/85		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Md.	
24. FUNERAL DIRECTOR NAME Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228				25a. DATE REC'D. BY REGISTRAR MAR 8 1985		25b. REGISTRAR'S SIGNATURE W. Davidson-Rendell	



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDWARD Nixon LEONARD</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3 13 85</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>May 7, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Flooring</b>	
13a. STATE <b>Deleware</b>		13b. COUNTY <b>Rehobeth</b>	
13c. CITY OR TOWN <b>Rehobeth</b>		13d. STREET ADDRESS / ZIP CODE <b>10 Gunpowder Ln 19971</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Maurice K. Leonard</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie E. Bixler</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-10-9051</b>	
17. INFORMANT <b>Catherine Leonard</b>		18. ADDRESS <b>Rehobeth, Del 19971</b>	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cordian arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Sense is chronic cordian arrest, COPD.</b> (c) <b>Acute Myeloblastic leukemia, acute leukemia.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION CITY OR TOWN COUNTY STATE		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/11 1985</b> to <b>3/13 1985</b> , that (I) (we) lost saw the deceased alive on <b>3/13 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Dr. J. Brevela</b>		22c. DEGREE <b>ATTENDING PHYSICIAN</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. J. Brevela</b>		22e. ADDRESS <b>Johns Hopkins Hospital Balt. MD</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Mar 16.85</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Dippel Funeral Homes, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 15 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. ADDRESS <b>7110 Belair Road Baltimore, Md. 21206</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been assigned by the attending physician, it should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove and retain the certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 signed, any injury, or other treatment, which the medical examiner could not see, should be stated in item 21.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8507795

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SIGMUND LEVIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 26, 1985</b>		2b. HOUR <b>11:46 PM</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 15, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6228 WOODCREST AVE. ( 21209)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LAWYER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT LAW</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6228 WOODCREST AVE. ( 21209)</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WOLF LEVIN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DENA SILVERMAN</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII-ARMY</b>		17. INFORMANT <b>MRS. CATHERINE FRESE</b>		ADDRESS <b>303 WINGATE RD. BALTO., MD 21210</b>			
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Prostate</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YRS</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 82</u> to <u>March 26 1985</u> , that (I) (we) lost saw the deceased alive on <u>March 13 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE <u>A.C. Alevizatos</u>				DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>3/27/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A.C. ALEVIZATOS, MD</b>				22e. ADDRESS <b>301 ST. PAUL PL. (21202)</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MAR. 29, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b>		23d. LOCATION CITY OR TOWN COUNTY <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS.</b> <b>6010 REISTERSTOWN RD. BALTIMORE, MD ( 21215)</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 2 - 1985</b>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the funeral home permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72-hour file/death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 7 7 9 6

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anthony Young Lewis SR			2a. DATE OF DEATH MONTH DAY YEAR 3/14/85			2b. HOUR M			
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 8 7 6 17		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W VA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School teacher		12b. KIND OF BUSINESS OR INDUSTRY BCSchools	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3809 Wabash Ave Apt D 21215	
14. FATHER'S NAME FIRST MIDDLE LAST Richard Robert Lewis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Racheal M. Minor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW II		16b. SOCIAL SECURITY NO. 235-14-6122		17. INFORMANT ADDRESS Anthony Y Lewis JR. 435 Ilchester Ave					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable recurrent myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Hypertensive arteriosclerotic cardiovascular disease									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 82, to Present, that (I) (we) lost saw the deceased alive on Feb 8 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Rifat Abousy			DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/15/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rifat Abousy			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/19./85		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD		
24. FUNERAL DIRECTOR NAME Nutter and Sons Funeral Home inc 2501 Gwynns falls PKWY Baltimore MD					25a. DATE REC'D. BY REGISTRAR APR 1 - 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2b. DATE OF DEATH		MONTH	DAY	YEAR	2c. HOUR	
George A. Lewis					3/19/85					11 P. M.	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	Black		11/12/17		67 YRS.		MONTHS		DAYS		HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.B.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		633 N. Woodington Road									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				633 N. Woodington Rd 21229	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Calvin		Louise		NO		225-10-4400		Anna V. Lewis		633 N. Woodington Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				seizure disorder						1 month	
				Hypertension						See yrs	
				ASCVD						See yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		M.D. old									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost		22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		Amatun N. Naeem		MD		3/21/85					
above, (I) (we) (did) (did not) view the body after death.		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
		AMATUN N. NAEEM		501. Dolphin Street, Baltimore							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
BURIAL		3/23/85		Arbutus Memorial Pk Arbutus,		CITY OR TOWN				Md.	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm C March F/H Inc.		1101 E North Avenue				MAR 22 1985		Randall			

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PO BOX 601  
CHILMARK MA 01928



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LILLIE MAE LEWIS</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>19</b> YEAR <b>85</b>		2b. HOUR <b>1</b> P.M.	
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>1</b> YEAR <b>26</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John L. Deaton Medical Center</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>901 Druid Park Lane Dr. 21217</b>		
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Taylor</b> LAST <b>Taylor</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Georgia</b> MIDDLE <b>Taylor</b> LAST <b>Taylor</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Joyce Keel 4923 Goodnow Rd.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1a) <b>Cardio respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last. (b) <b>Gastric Carcinoma of the Stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with Metastasis</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 min</b> <b>7 mo</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11c.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>March 19</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.						
22b. SIGNATURE <b>Harry S. Strothers III</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3/19/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harry S. Strothers III M.D.</b>				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3/20/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Pk.</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co.</b> STATE <b>MD</b>
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1985</b> 25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Russell T. Lewis</u>					2a. DATE OF DEATH MONTH <u>3</u> DAY <u>28</u> YEAR <u>85</u>			
3. SEX <u>M</u>					2b. HOUR <u>5:35</u> AM			
4. RACE <u>W</u>		5. DATE OF BIRTH MONTH <u>5</u> DAY <u>12</u> YEAR <u>1931</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>53</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD		
10. CITY OR TOWN OF DEATH <u>BALTIMORE</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>FRANCIS SCOTT KEY</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>ELECTRICIAN</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>AM. CAN CO.</u>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>BALTIMORE</u>		13c. CITY OR TOWN <u>DUNDALK</u>		13d. STREET ADDRESS / ZIP CODE <u>3444 YORKWAY 21222</u>		
14. FATHER'S NAME FIRST <u></u> MIDDLE <u></u> LAST <u></u>					15. MOTHER'S MAIDEN NAME FIRST <u>NANNIE</u> MIDDLE <u>HANKS</u> LAST <u></u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u> (IF YES, GIVE WAR OR DATES) <u>NAVY</u>					16b. SOCIAL SECURITY NO. <u>21726 0659</u>			
17. INFORMANT ADDRESS <u>RUSSELL S. LEWIS 6564 ST. HELENA AVE</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u></u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3/27</u> 19 <u>85</u> , to <u>3/28</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>John P Joyce</u> DEGREE <u>MD</u>				22c. DATE SIGNED <u>3/28/85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John P Joyce</u>				22e. ADDRESS <u>4940 Eastern Ave, Balt MD</u>				
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE <u>4/1/1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAKLAWN</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE MD</u>		
24. FUNERAL DIRECTOR NAME <u>RAYMOND L. KACZOROWSKI 2525 FLEET ST.</u>				25a. DATE REC'D. BY REGISTRAR <u>APR 1 - 1985</u>		25b. REGISTRAR'S SIGNATURE <u>John P Joyce</u>		

094114

## Abstract

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Thomas				Libertini	3	6	85		5:34PM
3. SEX	M.	4. RACE	W.	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
				July 8 1950	34		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (COUNTRY)	MD	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
					City MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
	Good Samaritan Hospital			President		Computer			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE				
Pa				New Freedom	19 Hilltop Rd		New Freedom Pa		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
James		Mary							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
		218-68-0258		Mrs Kim Libertini 19 Hilltop Rd #1 New Freedom Pa					

1. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Advanced lymphoma.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

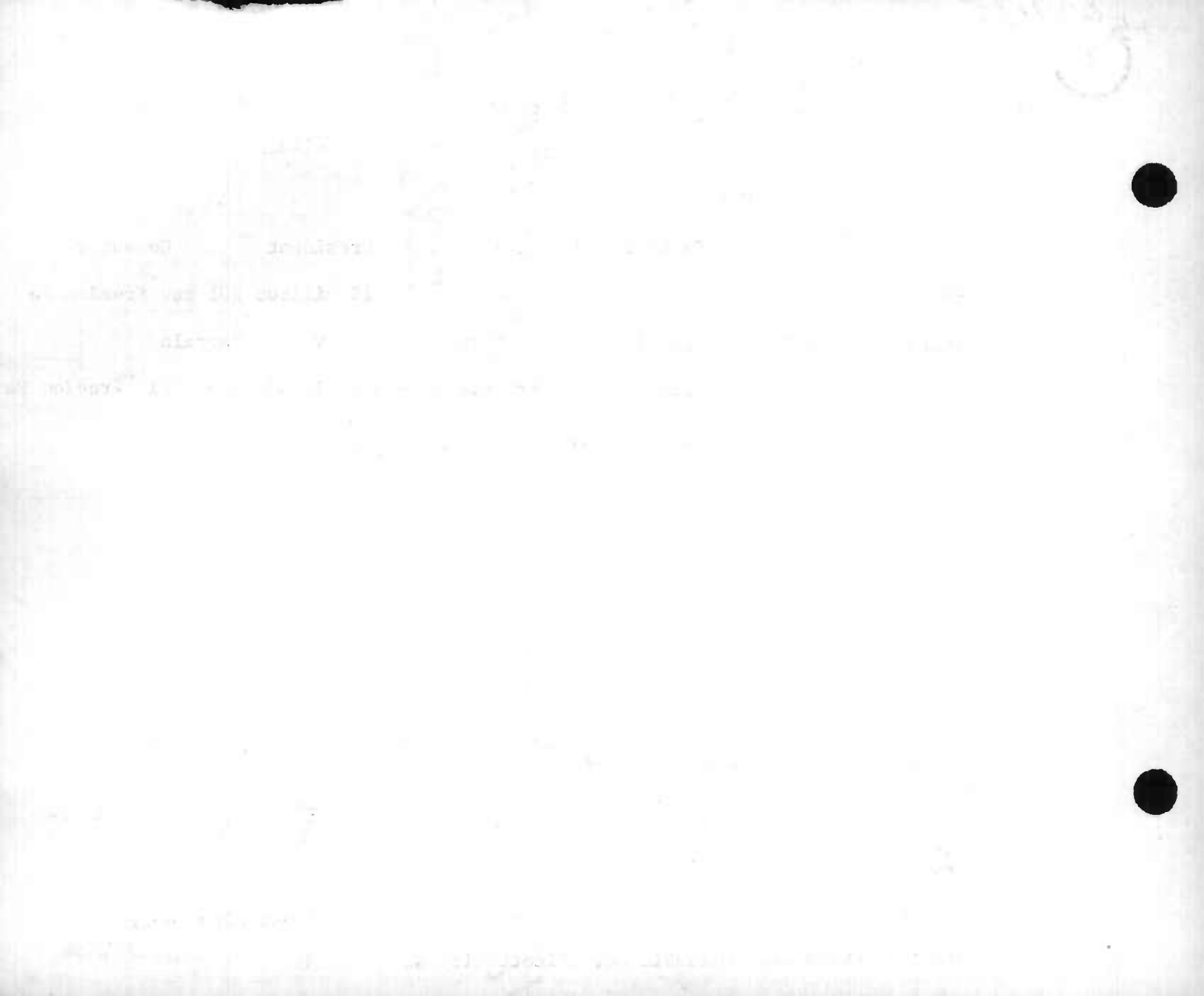
APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-1 19 85 to 3-6 19 85, that (I) (we) last saw the deceased alive on 3-6 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (which) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
Adel S. El-Hennawy	MD	3-6-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
Adel S. El-Hennawy	GSH.		

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 3-11-85	23c. NAME OF CEMETERY OR CREMATORY St Johns	23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City Howard Md
24. FUNERAL DIRECTOR Harry H Witzke		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE John Davidson-Rondelle
4112 Columbia Rd, Ellicott City		MAR 13 1985	





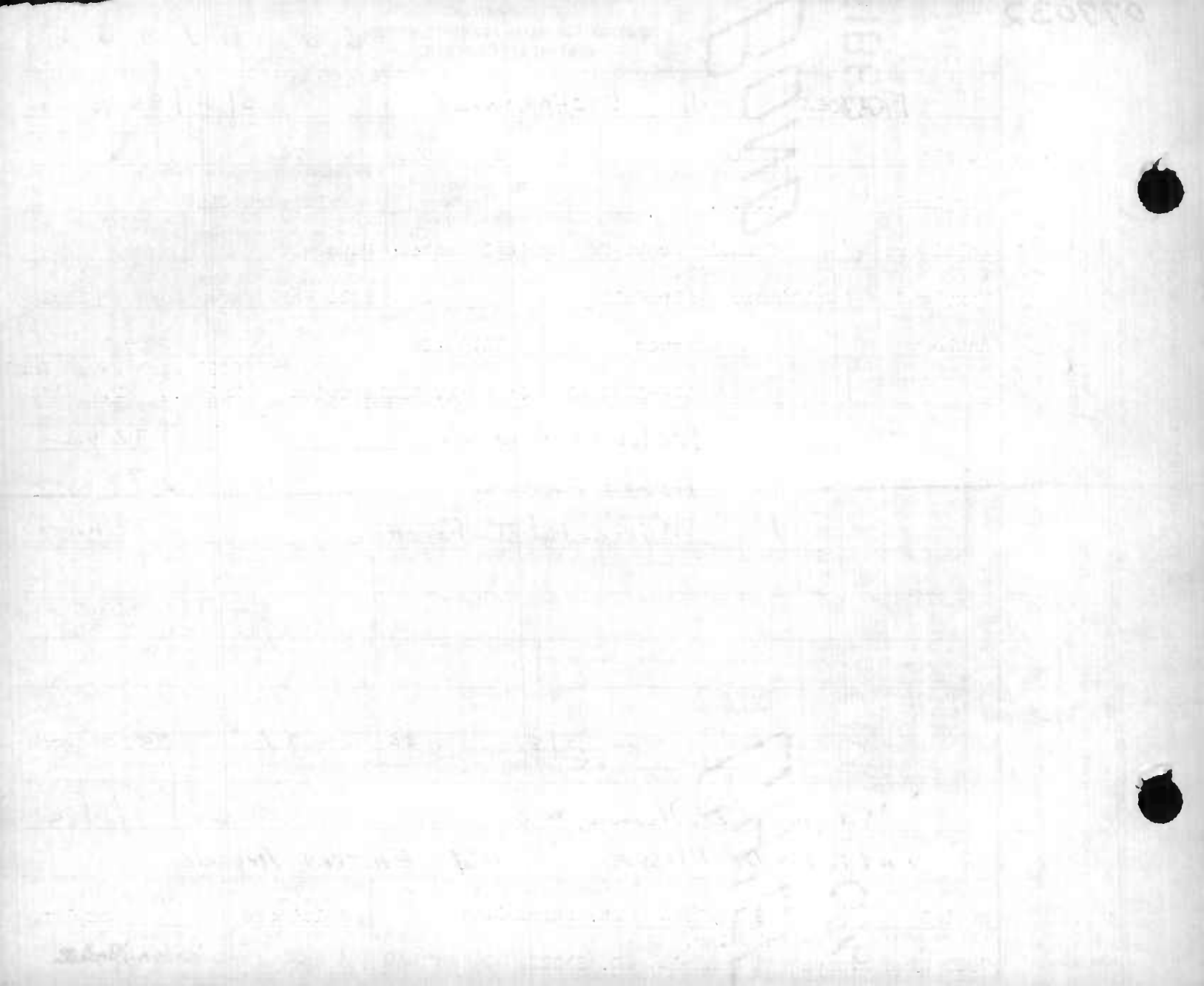
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 85 07801	
1. DECEASED NAME (TYPE OR PRINT) <b>FRANCES J. LICHAROWICZ</b>				2a. DATE OF DEATH MONTH <b>3</b> DAY <b>11</b> YEAR <b>85</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>3</b> YEAR <b>1910</b>		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Medical Center</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8033 Park Haven Road 21222</b>				
14. FATHER'S NAME FIRST <b>Anthony</b> MIDDLE <b>Marzec</b> LAST <b>Marzec</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Viktoria</b> MIDDLE <b>Gabyal</b> LAST <b>Gabyal</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-22-6961</b>		17. INFORMANT <b>James F. Licharowicz</b> ADDRESS <b>8031 Park Haven Road Balto., MD. 21222</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metabolic Acidosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart Failure</b>					<b>72 hours</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarction</b>					<b>72 hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <b>3/8</b> , 19 <b>85</b> , to <b>3/11</b> , 19 <b>85</b> , that (1) (we) last saw the deceased alive on <b>3/11</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.						
22b. SIGNATURE <b>Raymond D. Mossie, M.D.</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/11/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAYMOND D. MOSSIE</b>		22e. ADDRESS <b>4940 EASTERN AVENUE</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/14/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		
23d. LOCATION CITY OR TOWN <b>Baltimore</b>		COUNTY <b>Maryland</b>		STATE		
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Minnie</i> MIDDLE <i>A.</i> LAST <i>Ligon</i> <i>Elmura M. Ligon</i>		2a. DATE OF DEATH MONTH <i>3</i> DAY <i>3</i> YEAR <i>85</i>		2b. HOUR <i>1:10 P.M.</i>
3. SEX <i>Female</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH <i>11</i> DAY <i>21</i> YEAR <i>12</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALT. CITY</i> MD.
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>PROVIDENT</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>		13b. COUNTY	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <i>Willie</i> MIDDLE <i>Haskins</i> LAST <i>Haskins</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Betty</i> MIDDLE <i>Hanks</i> LAST <i>Fowlkes</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>212-26-6609</i>		17. INFORMANT ADDRESS <i>Lawrence E. Jones 3701 Liberty Hgts Av</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Possible cerebrovascular accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>2/28</i> , 19 <i>85</i> , to <i>3/3</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3/3/85</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>A. Shabarik</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>3/3/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. SHABAIK</i>		22e. ADDRESS <i>PROVIDENT HOSPITAL</i>		
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>	23b. DATE <i>3/8/85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Memorial Pk.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Arbutus, Md.</i>
24. FUNERAL DIRECTOR NAME <i>WM. C. March F.H. 1101 E. North Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 5 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Gaila Davidson-Randall</i>

MEDICAL CERTIFICATION

02/20

RECEIVED  
COMMUNICATIONS SECTION  
MAR 2 1966

100-100000

100-100000

RECEIVED  
COMMUNICATIONS SECTION  
MAR 2 1966

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbalgopans. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		P. M.	
1. DECEASED NAME (TYPE OR PRINT) <b>J. ORVILLE LILLY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>03-09-85</b>		2b. HOUR <b>5:30</b>						
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 12 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.							
10. CITY OR TOWN OF DEATH <b>BALTIMORE CITY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHURCH HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Coal Miner &amp; Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Helliwig Const.</b>					
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4012 E. Northern Pkwy. 21206</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Josiah Mann Lilly</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie May Myers</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>236-05-6978</b>		17. INFORMANT ADDRESS <b>Dorothy B. Lilly 4012 E. Northern Pky. Baltimore, Md. 21206</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio - Pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIO- PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) <u>3/9</u> <u>3-9-85</u> <u>19 85</u> attended the deceased from <u>3/9</u> <u>3-9-85</u> <u>19 85</u> to <u>3/9</u> <u>3-9-85</u> <u>19 85</u> that (I) <u>viewed</u> <u>last</u> saw the deceased alive on <u>3/9</u> <u>3-9-85</u> <u>19 85</u> and that in (my) <u>four</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> <u>view</u> the body after death.													
22b. SIGNATURE <b>Brian D. Zuckerman</b> DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/9/85</b>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRIAN ZUCKERMAN</b>		22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 21231 BALTO., MD</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-13-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake Mount Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Davidsonville, Maryland</b>							
24. FUNERAL DIRECTOR NAME <b>Lassano Funeral Home</b>		24b. ADDRESS <b>7401 Belair Rd BALTO. MD 21234</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

93817 10/10/00 0003

10/10/00 0003



Handwritten signature or initials.

ET RAM

080106

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>EVELYN</b>		FIRST <b>EVELYN</b> MIDDLE <b>SPARLING</b> LAST <b>LINTHICUM</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>MAR 15 1985</b>		2b. HOUR <b>9<sup>30</sup></b> M	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT 10 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Detroit, Michigan</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian-Long Green Nursing Center -21212</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housework</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. STREET ADDRESS <b>36 Whitfield Road - 21210</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Sparling</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret May Potter</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-44-3891</b>		17. INFORMANT ADDRESS <b>John S. Hebb, III - 10 Light Street-21202</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**ARTERIOSCLEROTIC HEART DIS**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**5 DAYS**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

**GENERALIZED ARTERIO SCLEROSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

**PERIPHERAL ARTERIO SCLEROSIS**

19a. DATE OF OPERATION <b>---</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>---</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>---</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>---</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>---</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 10, 1963</b> to <b>MAR 15, 1985</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>MAR 13, 1985</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, check <input type="checkbox"/> above.)							
23a. SIGNATURE <b>John M. Scott</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23b. DATE SIGNED <b>3/15/85</b>	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN M. SCOTT</b>		23d. ADDRESS <b>600 W. NORTHERN PARKWAY 21210</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Mar. 16, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematorium</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Md. 21202</b>	
24. FUNERAL DIRECTOR NAME <b>Henry Sander &amp; Sons, Inc., Balto., Md. -21213</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.



2030



081321

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 3 should be filed with you after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8507805

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		10:30 A.	
James Melvin LITTLE		March 9, 1985			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	68	MONTHS DAYS	
		December 15, 1916		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	2725 Northshire Drive		Operator		M.T.A.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	////////////////	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2725 Northshire Drive 21230	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Arthur G. Little		Laura Green			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		W.W. II 216.09.2304		Dorothy R. Little (wife) Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pleural Effusion Right Lung</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adeno Carcinoma Right Lung</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Atherosclerotic Cardiovascular Disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1983</u> to <u>March 9, 1985</u> , that (I) (we) lost					
saw the deceased alive on <u>Feb 18, 1985</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Victor S. Roth M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		Mar. 11, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<u>Victor S. Roth M.D.</u>		700 Washington Boulevard			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Mar. 12, 1985		Md. Veterans Cem.	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
CITY OR TOWN COUNTY STATE		MAR 12 1985		<u>Jane Davidson-Randall</u>	
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR			
NAME ADDRESS					
<u>Singleton Funeral Home, Glen Burnie, Maryland</u>					

BP

2087

081321



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081113

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH85 07806  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>George Little John</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3-13-85</b>		2b. HOUR <b>11:12 A.M.</b>	
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 15 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Potts &amp; Callahan</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1929 N. Fulton Ave. Baltimore, Maryland 21217</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Little John</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ernestine Hemphill</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>247-42-0566</b>	17. INFORMANT ADDRESS <b>Mrs. Jeanette Littlejohn Balto. Md. 21217</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac - Pulmonary Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Failure</b>		<b>3 mos</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Multiple Myeloma</b>		<b>3 mos</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/10/85</b> , 19 <b>85</b> , to <b>3/13</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/13</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>P. Kent</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>3/13/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. Kent</b>		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/18/1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City MD</b>
24. NAME OF FUNERAL HOME <b>Funeral Home, Inc. Baltimore, Maryland 21216</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1985</b>	25b. REGISTRAR'S SIGNATURE <b>John D. ...</b>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



081322

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 7 8 0 7

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nellie Marie Litzau			2a. DATE OF DEATH MONTH DAY YEAR 3 5 85		2b. HOUR M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3 18 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Stokes Read			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Virginia Gickman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-74-9477		17. INFORMANT ADDRESS Mr Harry A. Litzau Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Exacerbated - DHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-5-85</u> , 19 <u>85</u> , to <u>3-5-85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3-5-85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>George Angov</u>		DEGREE		22c. DATE SIGNED <u>3-5-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Angov, M.D.		22e. ADDRESS 3350 Wilkens Ave. Balto., Md. 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-8-85	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md	
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home		ADDRESS Catonsville Md		25a. DATE REC'D. BY REGISTRAR MAR 5 1985	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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086042

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 0 8

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John H. Lloyd			2a. DATE OF DEATH MONTH DAY YEAR 3 22 85		2b. HOUR 1:23 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 14 1923	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Cen.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Officer	12b. KIND OF BUSINESS OR INDUSTRY Hosp.	
13a. STATE Md.			13b. COUNTY -	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles Lloyd			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Grap		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17. INFORMANT ADDRESS Catherine Lloyd (wife) same address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G-I Bleed</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>prolonged intubation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> <u>18 day</u> <u>18 day</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a. <u>Hypertension</u>					
19a. DATE OF OPERATION <u>3/15</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>hypertension</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> , 19 <u>85</u> , to <u>3/22</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/22</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Steven J. Kithner</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3-22-85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Steven J. Kithner</u>			22e. ADDRESS <u>Francis Scott Key Medical Center</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE <u>3/25/85</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Schimunek Funeral Home, Inc.</u> ADDRESS <u>3331 Brehms Lane, Balto. Md. 21215</u>			25a. DATE REC'D. BY REGISTRAR <u>MAR 26 1985</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

BP



026013

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094134

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 0 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>BABY GIRL LOCKMAN</b>			2a DATE OF DEATH MONTH DAY YEAR <b>3/13/85</b>			2b HOUR <b>7:00 AM</b>				
3 SEX <b>F</b>		4 RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3/13/85</b>			6 AGE (IN YEARS (LAST BIRTHDAY)) <b>0</b> YRS.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.				
10 CITY OR TOWN OF DEATH <b>BALTO CITY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSP</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>		12b KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD</b>			13b COUNTY <b>BALTO</b>		13c CITY OR TOWN <b>BALTO</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>3304 N. HILTON ST.</b> 21216	
14 FATHER'S NAME FIRST MIDDLE LAST <b>LOCKMAN, INGRID</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOCKMAN, INGRID</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT ADDRESS <b>MERCY HOSP.</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Severe Prematurity</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Severe Prematurity</b> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Severe Prematurity</b>										
19a DATE OF OPERATION <b>—</b>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <b>3/13/85</b> to <b>3/13/85</b> that (I) (we) last saw the deceased alive on <b>3/13/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>R.E. Marshall</b>						DEGREE <b>M.D.</b>		22c DATE SIGNED <b>3/13/85</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.E. MARSHALL</b>						22e ADDRESS <b>MERCY HOSP. 301 St. Paul Pl</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b DATE <b>3/28/85</b>		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME <b>Anatomy Board</b>						ADDRESS <b>Balto., Md.</b>		25a DATE REC'D. BY REGISTRAR <b>APR 1 - 1985</b>		
						25b REGISTRAR'S SIGNATURE <b>John Swindon Anderson</b>				

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

REG. NO.

07810

1. DECEASED NAME (TYPE OR PRINT) IRENE ELSIE LOESER			2a. DATE OF DEATH MONTH DAY YEAR MARCH 9, 1985			2b. HOUR 7:17 P M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 24, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 yrs. YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TRENTON, N.J.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3504 MT. PLEASANT AVE. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE DIGGS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY WEBB				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213.03.9529		17. INFORMANT ADDRESS Irene E. Collis 7238 Martell Ave. Dundalk, Maryland 21222					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Internal Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>8.7 cm. Thoracic Aortic Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable Atherosclerotic Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>~ 2 years</u> <u>~ 30 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>March 9, 1985</u> , to <u>March 9, 1985</u> , that (I) (we) last saw the deceased alive on <u>March 9, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>G.M. GACIOCH</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.M. GACIOCH			22e. ADDRESS JOHNS HOPKINS HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 3/12/1985		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY INC.,					ADDRESS DUNDALK, MD. 21222		25a. DATE REC'D. BY REGISTRAR MAR 12 1985		
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician, it should be filed in by the funeral director. Page 3 should be detached for use as the burial permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 1 1

REG. NO.

FOR  
1 - STATE  
REGISTRAR

088007

1 DECEASED NAME (TYPE OR PRINT) CARRIE H. LONG			2a DATE OF DEATH MONTH DAY YEAR March 21 1985		2b HOUR 9:50 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Sept. 6, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD	
10 CITY OR TOWN OF DEATH BALTIMORE CITY	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Payroll Clerk		12b KIND OF BUSINESS OR INDUSTRY Western Union
13a STATE MD	13b COUNTY Balto.	13c CITY OR TOWN Balto.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 830 W. 40th St., 21211
14 FATHER'S NAME FIRST MIDDLE LAST Fletcher Long		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Horner			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 212 03 9302		17 INFORMANT ADDRESS Annabelle L. Smith, Same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia, Staph aureus, Pseudomonas aeruginosa</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>interstitial fibrosis, Abundant stenosis congestive heart failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>2/19</u> 19 <u>85</u> , to <u>3/21</u> 19 <u>85</u> , that (I/we) last saw the deceased alive on <u>3/20</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>David S. Dunn</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <u>3/21/85</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DAVID S. Dunn		22e ADDRESS 201 E. University Pkwy			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 3/22/85		23c NAME OF CEMETERY OR CREMATORY Green Mount	
23d LOCATION CITY OR TOWN COUNTY STATE Balto., MD					
24 FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212		25a DATE REC'D. BY REGISTRAR MAR 26 1985		25b REGISTRAR'S SIGNATURE <u>David S. Dunn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

082007

First Name	White	Sex	Male	City	Frederick, Md.
MD	USA				
Birth Date	1950	Birth Place	Frederick, Md.	Home	Frederick, Md.
MD					
First Name	Long	Sex	Male	City	Frederick, Md.
MD					
Birth Date	1950	Birth Place	Frederick, Md.	Home	Frederick, Md.
MD					

Handwritten notes and signatures are present in the lower half of the page, including a large signature that appears to read "John W. Jenkins & Sons Co." and other illegible markings.



093144

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 7 8 1 2

1. DECEASED NAME (TYPE OR PRINT) <b>Daisy</b> <b>IRMA</b> <b>Long</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3</b> <b>28</b> <b>85</b>		2b. HOUR <b>3<sup>00</sup></b> <b>PM</b>
3. SEX <b>Female</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6</b> <b>29</b> <b>07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore Gen. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Material Distributor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O R.R.</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1124 Sargeant St. 21223</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob</b> <b>Mueller</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary</b> <b>E</b> <b>Walton</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215242524</b>		17. INFORMANT <b>Robert J. Long</b> ADDRESS <b>1124 Sargeant Street 21223</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Adenocarcinoma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>pancreatic adenocarcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION <b>2/27/85</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer - unknown primary</b>	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>P.M.</b> <b>19</b>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M.</b> <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3001 S. Hanover St. Baltimore Maryland</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/16</b> , 19 <b>85</b> , to <b>3/25</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/25</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death.			
22b. SIGNATURE <b>[Signature]</b>		DEGREE	22c. DATE SIGNED <b>3/28/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL CAMPO M.D.</b>		22e. ADDRESS <b>3001 S. Hanover St.</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>4/1/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 1 1985</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP





086031

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DONALD CHARLES LOSS			2a. DATE OF DEATH MONTH DAY YEAR 3/24/85		2b. HOUR 10:45 a.m.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 3, 1926	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	9. CITIZEN OF WHAT COUNTRY? U.S.A.	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
12. CITY OR TOWN OF DEATH Baltimore City	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager	15. KIND OF BUSINESS OR INDUSTRY C.&P. Telephone	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland 16b. COUNTY Baltimore 16c. CITY OR TOWN Catonsville			17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	18. STREET ADDRESS / ZIP CODE 1208 Redcliffe Road 21228	
19. FATHER'S NAME FIRST MIDDLE LAST Charles Frances Loss			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Helen Debus		
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		22. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2	23. INFORMANT ADDRESS Eileen R. Loss Same as # 13		
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Complete heart block</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED		26a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
27d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		27e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27f. LOCATION STREET CITY OR TOWN COUNTY STATE	
28. I certify that (I) (this hospital) attended the deceased from <u>3/22</u> , 19 <u>85</u> , to <u>3/24</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/24</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
29a. SIGNATURE <u>R. Girgis</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		29b. DATE SIGNED	
29c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Raufat Y. Girgis</u>		29d. ADDRESS <u>St. Agnes Hospital - Baltimore Md.</u>			
30a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	30b. DATE 3/27/85	30c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		30d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Maryland	
31. FUNERAL DIRECTOR NAME ADDRESS Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228		32. DATE REC'D. BY REGISTRAR MAR 26 1985		33. REGISTRAR'S SIGNATURE <u>L. Davidson-Randall</u>	

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
REG. NO. 85 07814									
1. DECEASED NAME (TYPE OR PRINT) ALONZO R. LOVE					2a. DATE OF DEATH MONTH DAY YEAR 03 13-85		2b. HOUR 8:38 PM		
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 02-21-12		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Catheran				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS / ZIP CODE 1809 Ruxton Avenue 21216			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Love					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Holloway				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-09-0547		17. INFORMANT ADDRESS Emma Love 1809 Ruxton Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetic ketoacidosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>03-13-85</u> , 19 <u>85</u> , to <u>03-13-85</u> , 19 <u>85</u> , that (we) lost saw the deceased alive on <u>03-13-85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 03-13-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SISSA Anoka					22e. ADDRESS Lutheran Hospital				
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 3/19/85		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.		
24. FUNERAL DIRECTOR Wm C March F/H Inc. 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR MAR 18 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARY LOVE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 12 85</b>			2b. HOUR <b>7 A M</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-18-1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Harford Cty.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE CITY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waitress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hutzler's-Ret.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>			13b. COUNTY <b>Balto., City</b>		13c. INSIDE CITY LIMITS? <b>YES</b> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>4434 Raspe Ave. 21206</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Willson Rahl</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Lynch</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-01-1619</b>		17. INFORMANT <b>Nicholas. B. Wessells, 4434 Raspe Ave</b>				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Urinary Tract Infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Electrolyte imbalance, CHF</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Electrolyte imbalance, CHF</b>										
19a. DATE OF OPERATION <b>2-25-85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Urinary Tract Infection</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>Urinary Tract Infection</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Union Memorial Hospital Baltimore Maryland</b>						
22a. I certify that (1) this hospital attended the deceased from <b>2-25-85</b> to <b>3-12-85</b> , that (1) we lost saw the deceased alive on <b>3-12-85</b> , and that in (a) our opinion death occurred on the date and hour and from the causes stated (b) we (c) did (did not) view the body after death.										
22b. SIGNATURE <b>Lasaundra Watson MD</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>								22c. DATE SIGNED <b>3/12/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LASAUNDR A WATSON, M.D.</b>				22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-15-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>John C. Miller, Inc. 6415 Belair Rd. 21206</b>						DATE RECEIVED BY REGISTRAR <b>MAR 14 1985</b>				

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 1 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LENA LOVETT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 20 85</b>		2b. HOUR <b>2:05</b> <sup>A</sup>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4/20/1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Saint Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Domestic Serv./Self-Employ</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Lovett</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carolyn Hensley</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>414-10-7222</b>	
17. INFORMANT <b>Faye Burns</b>		18. ADDRESS <b>3820 Second St., Balto., Md.</b>		19. ZIP CODE <b>21225</b>		20. DATE OF OPERATION <b>3-13-85</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-13-85</b> to <b>3-19-85</b> , that (I) (we) lost saw the deceased alive on <b>3-19-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>EDNA S YEO</b>		22c. DATE SIGNED <b>3-19-85</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ST AGNES HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/22/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, A. A. Co., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>McGully Funeral Homes</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1985</b>		25b. REGISTRAR'S SIGNATURE		25c. DATE OF DEATH <b>3-20-85</b>	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **cardiac arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **myocardial infarct**

DUE TO, OR AS A CONSEQUENCE OF

(c) **MI, CHF**

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

**paroxysmal atrial tachy., supravent. tachycardia, Aspiration**19a. DATE OF OPERATION  
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
20a. AUTOPSY?  
YES ☐ NO ☒  
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)  
21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
**19**21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  
21d. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐  
21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from **3-13-85** to **3-19-85**, that (I) (we) lost  
saw the deceased alive on **3-19-85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.22b. SIGNATURE  
**EDNA S YEO**  
22c. DATE SIGNED  
**3-19-85**  
22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
**ST AGNES HOSPITAL**23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)  
**Burial**  
23b. DATE  
**3/22/1985**  
23c. NAME OF CEMETERY OR CREMATORY  
**Glen Haven Mem. PK.**  
23d. LOCATION  
CITY OR TOWN COUNTY STATE  
**Glen Burnie, A. A. Co., Md.**24. FUNERAL DIRECTOR  
NAME  
**McGully Funeral Homes**  
25a. DATE REC'D. BY REGISTRAR  
**MAR 21 1985**  
25b. REGISTRAR'S SIGNATURE  
25c. DATE OF DEATH  
**3-20-85**25d. ADDRESS  
**237 E. Patapsco Ave., Balto., Md., 21225**



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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DORIS MAE LOVING			2a. DATE OF DEATH MONTH DAY YEAR 3 20 85		2b. HOUR 5:45 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 06 05 16		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUYER	12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTO. HGLDS.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ROLLO EDWARD GOODSELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLY MAE WHALER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 104-03-6076	17. INFORMANT ADDRESS PATRICIA ANN PEASE 1593 DULANEY LANE 21061		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA & CONGESTION DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE METABOLIC ENKEPHALOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) GRAM NEGATIVE URINARY TRACT INFECTION					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James E. Taylor M.D.		DEGREE M.D.		22c. DATE SIGNED 3/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E. TAYLOR		22e. ADDRESS ST AGNES HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 03-23-85	23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PARK	23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MARYLAND		
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR MAR 22 1985	25b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



James Taylor and his wife  
Rosa C. Taylor at home: Hopkins

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

DECEASED NAME (PRINT) <b>MAGGIE N. LOWE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 26, 1985</b>		2b. HOUR <b>11:40<sup>AM</sup></b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 29, 1894</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GARDEN VILLAGE N. HOME</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AT HOME</b>		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE <b>4220 HAMILTON AVE. 21206</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>223 92 9602</b>		17. INFORMANT <b>FAMILY RECORDS</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Auto Cardiovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Recurrent Urinary Tract Infection; Chronic Cholecystitis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7/18/80</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>7/18/80</b>	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3/26/85</b>		22a. I certify that (I) (the hospital) attended the deceased from <b>3/26/85</b> to <b>3/26/85</b> that (I) (we) lost above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <b>Albert B. Bradley</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <b>MARCH 27, 1985</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. ALBERT B. BRADLEY</b>		22e. ADDRESS <b>4900 BELAIR ROAD - BALTIMORE</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>OAK GROVE CSM.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON VA.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>EVANS CHAPEL OF MEMORIES HARBOR 8800 RD.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 4 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>Wardson-Pandele</b>					

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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*[Faint, mostly illegible handwritten text, possibly a letter or report.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 1 9

10 092146

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Shirley MAE LOWE</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3-27-85</i>		2b. HOUR <i>5:05 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6-30-34</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>50</i> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City, MD.</i>
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Baltimore Gen. Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sales-lady</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retail store</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Md.</i>			13c. COUNTY <i>Anne Arundel</i>		13d. CITY OR TOWN <i>Pasadena</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph - Marra</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>GLADYS - BARNES</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>234-52-9415</i>		17. INFORMANT ADDRESS <i>Ronald G. Lowe / 7904 Elizabeth Rd. (21122)</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Gastric Carcinoma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>March 26</i> , 19 <i>85</i> , to <i>March 27</i> , 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>March 27</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Jorge J. Acevedo Vilhi</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>3/27/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jorge J. Acevedo Vilhi</i>				22e. ADDRESS <i>3001 S. Hanover St. Baltimore, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-30-1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY <i>Clarksburg, Harrison Co. W. Va.</i>
24. FUNERAL DIRECTOR NAME <i>Mc Cully Funeral Home, Pasadena, Md. 21122</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 29 1985</i>		

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIE B. LUNGER			2a. DATE OF DEATH MONTH DAY YEAR March 24, 1985		2b. HOUR 1:00P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 14, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE MD	13b. COUNTY Balto.	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8408 Greenway Road, 21234	
14. FATHER'S NAME FIRST MIDDLE LAST William Barnhart		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Mumma			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212 03 5441		17. INFORMANT John Barnhart, Hydes, Maryland 21082	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) End Stage of Chronic Obstructive Pulmonary

DUE TO, OR AS A CONSEQUENCE OF

Disease

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>February 28</u> , 19 <u>85</u> , to <u>March 24</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>March 24</u> , 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I <input checked="" type="checkbox"/> we) (did) (do not) view the body after death.					
22b. SIGNATURE <u>J. Boston</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>3/24/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose Boston, M.D.		22e. ADDRESS c/o Maryland General Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/27/85	23c. NAME OF CEMETERY OR CREMATORY Wilson United Meth.	23d. LOCATION CITY OR TOWN COUNTY STATE Long Green, MD
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212		25a. DATE REC'D. BY REGISTRAR MAR 26 1985	25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07821  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Troy Lumpkin</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3-21 1985</b>			2b. HOUR M <b>5:38</b>		
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 30 1943</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>42 YRS.</b>	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3-21 1985</b>			2d. HOUR M <b>a. M</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Creator Director</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Senior V.P.</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>10 Bishops Road 21218</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Pickett Lumpkin (Dec.)</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Isabel (nee Council)</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>575-42-1096</b>		17. INFORMANT <b>Nancy Sands</b> ADDRESS <b>10 Bishops Road, Baltimore, MD 21218</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>3-21-85</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>		ADDRESS <b>111 Penn St., Balto., Md. 21201</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3/22/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Baltimore MD.</b>		
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b>				25a. DATE REC'D BY REGISTRAR <b>MAR 26 1985</b>				
8728 Liberty Road Randallstown, Maryland 21133				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REGISTER THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR TO EXECUTE THE CERTIFICATE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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AMERICAN MEDICAL ASSOCIATION

1902 OCTOBER 20TH

Chicago, Ill.

W. H. ...

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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0 7 8 2 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHRISTOPHER L. LYDA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 30, 1985</b>		2b. HOUR P <b>9:40 M</b>						
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 8, 1969</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>15</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		IF UNDER 24 HRS HOURS MIN. <b>YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>SC</b> 13b. COUNTY <b>Greenville</b> 13c. CITY OR TOWN <b>Fountain Inn</b> 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						13e. STREET ADDRESS / ZIP CODE <b>102 Garrett St., 29644</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Barry Bruce Lyda</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sara Garrett</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <b>James Cannon Funeral Directors, SC</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CIRCULATORY COLLAPSE / CARDIAC ARREST</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SEPTICEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>~ 4 DAYS.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>02-05-</b> 19 <b>85</b> to <b>03-30-</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>03-30-</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.											
22b. SIGNATURE <b>S.P. SZOMBATHY M.D.</b>						DEGREE <b>MD.</b>		22c. DATE SIGNED <b>3/30/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S.P. SZOMBATHY, M.D.</b>						22e. ADDRESS <b>600 N. WOLFE ST. BALTO. MD.</b> <b>THE JOHNS HOPKINS HOSPITAL 21205</b>					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Removal-Burial</b>		23b. DATE <b>4/2/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cannon Mem. Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fountain Inn Gr., Villes, SC</b>			
24. FUNERAL DIRECTOR <b>Henry W. Jenkins &amp; Sons Co.</b> <b>4905 York Road Balto., MD 21212</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 2 1985</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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JAN 10 1964

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JAN 10 1964

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JAN 10 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/interment permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is completed, item 18 should not be completed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 2 3

FOR 1. STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Sterling Lynch</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>3 29 85</i>	
3. SEX <i>M</i>		4. RACE <i>B</i>	
5. DATE OF BIRTH MONTH DAY YEAR <i>9 16 15</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS	
7a. BIRTHPLACE (COUNTRY OR FOREIGN) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hospital</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>-</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Harford</i>	
13c. CITY OR TOWN <i>Maryland</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <i>1300 E. Lanvale Street 21213</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jene Lynch</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nettie Robinson</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Unknown</i>		16b. SOCIAL SECURITY NO. <i>231 340 251</i>	
17. INFORMANT ADDRESS <i>Martha Stansbury 1021 N. Caroline St.</i>			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/7</i> , 19 <i>85</i> , to <i>3/29</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3/29</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.			
22b. SIGNATURE <i>Gregory Lanpher</i>		22c. DATE SIGNED <i>3/29/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gregory Lanpher</i>		22e. ADDRESS <i>Lutheran Hospital</i>	
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>		23b. DATE <i>4/4/85</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Eastview Mem. Pk.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Wm. C. March F/H Inc. 1101 E North Avenue</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 1 - 1985</i>	
25b. REGISTRAR'S SIGNATURE <i>Galia Davidson-Randall</i>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

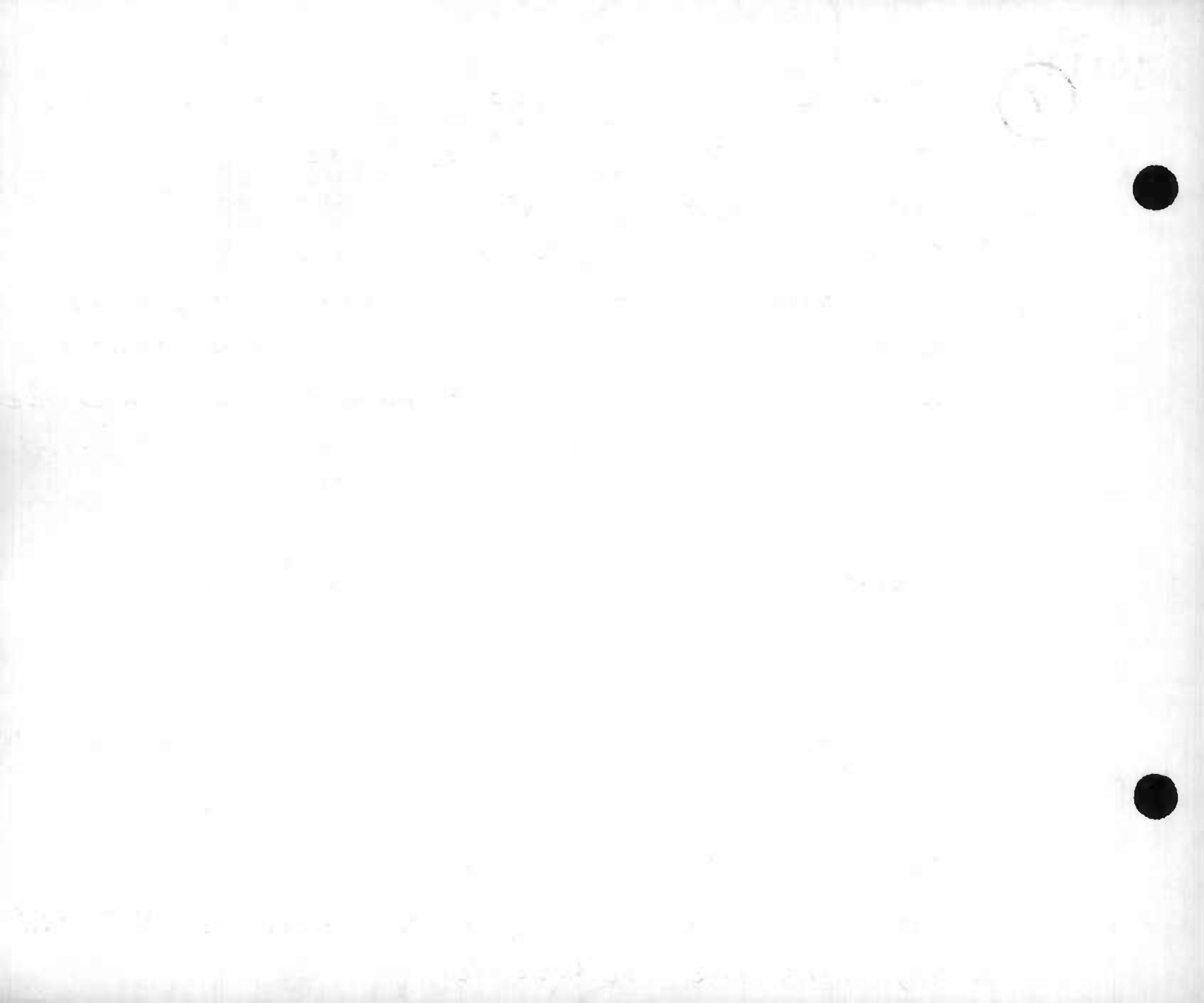
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FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RUTH MABE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 30 85</b>			2b. HOUR <b>8:45 A.M.</b>				
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 7 32</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H.S.W.F.</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD.</b>			13b. COUNTY <b>BALT</b>		13c. CITY OR TOWN <b>BALT</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4800 YELLOWOOD 21209</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ERNEST MATHEW MABE</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA GURDON MABE</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>237-72-0503</b>		17. INFORMANT ADDRESS <b>LINDA HARTZOG 502 N MILTON AVE</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 MINUTES</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAL DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>OBESITY, DIABETES, HX OF MYOCARDIAL INFARCTION</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from <b>3/19</b> , 19 <b>85</b> , to <b>8/30</b> , 19 <b>85</b> , that (II) (we) lost saw the deceased die on <b>3/30</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death.										
22b. SIGNATURE <b>David J. Sherer MD</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/30/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID J. SHERER MD</b>				22e. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>4/1/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SECURITY PROCESS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CADDOVILLE BALT MD</b>			
24. FUNERAL DIRECTOR NAME <b>CONNELLY FUNERAL HOME</b>				ADDRESS <b>300 MACE AVE</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 4 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

 MEDICAL CERTIFICATION  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 11, any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HUGH S. MACKEY			2a. DATE OF DEATH MONTH DAY YEAR Mar 29 1985 12-15 P.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 6, 1895	6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Keswick Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President	12b. KIND OF BUSINESS OR INDUSTRY Federal Land Bank	
13a. STATE MD		13b. COUNTY Balto.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 200 Cross Keys Rd., 21210	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Mackey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lyman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES Yes WW I		16b. SOCIAL SECURITY NO. 216 44 3551	17. INFORMANT ADDRESS Mrs. Olive R. Mackey, Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 YRS
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 15 Nov 19 83 to 29 MAR 19 85, that (I) (we) last saw the deceased on 29 Mar 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Aubrey D. Richardson, MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 29 MAR 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Keswick Home, Balto., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/1/85	23c. NAME OF CEMETERY OR CREMATORY Montrose Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Montrose, PA		
24. FUNERAL DIRECTOR NAME 4905 York Road Balto., MD 21212		25a. DATE REC'D. BY REGISTRAR APR 2 1985		25b. REGISTRAR'S SIGNATURE John R. ...	

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## MEDICAL CERTIFICATION

DHMH - 16 50M 4/83  
(VRA 15, 4)

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 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Peggy D. MADDEN			2a. DATE OF DEATH MONTH DAY YEAR March 23 1985			2b. HOUR 2:30p.m.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 15 1923		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4003 N. Charles St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4003 N. Charles St. 21218	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Parker					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Magdalena Warner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-18-5367		17. INFORMANT Henry B. Madden			ADDRESS Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatous</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CA of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>3-23-85</u> to <u>3-23-85</u> , that (I) (we) last saw the deceased alive on <u>3-23-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I we did and do not view the body after death)										
22b. SIGNATURE <u>[Signature]</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3-25-85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. A. Peter vanBerkum M.D.						22e. ADDRESS 3925 Beech Ave., Balto., Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-25-85		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD.				
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co., Balto., Md.						25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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U.S. AIR FORCE

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D.C.

1. The following information is being furnished to you for your information:

2. The following information is being furnished to you for your information:

3. The following information is being furnished to you for your information:

4. The following information is being furnished to you for your information:



5. The following information is being furnished to you for your information:

6. The following information is being furnished to you for your information:

7. The following information is being furnished to you for your information:

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13. The following information is being furnished to you for your information:

14. The following information is being furnished to you for your information:

15. The following information is being furnished to you for your information:



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST <b>MARYETTA MADDOX</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3-13-85</b>		2b. HOUR <b>9:50 PM</b>	
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-23-47</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>37</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SO. CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemp.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WALTER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARZOLA SAMUEL</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214 440639</b>	
17. INFORMANT ADDRESS <b>MARZOLA THOMPSON 2943 W. CAMVALE ST</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration, massive</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Upper GI bleeding</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Breast cancer with metastasis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hypoglycemia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3/8 1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1940 W. BALTIMORE ST. BALTIMORE MD</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/13 1985</b> to <b>3/13 1985</b> , that (I) (we) last saw the deceased alive on <b>3/13 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>JUAN BELTRAN</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-13-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JUAN BELTRAN</b>		22e. ADDRESS <b>1940 W. BALTIMORE ST. BALTIMORE MD 21203</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-18-85</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto Md.</b>		24. FUNERAL DIRECTOR NAME <b>Leroy O. Dyett</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 15 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

081324

FOR  
STATE  
REGISTRAR James J. Madej

1. DECEASED NAME (TYPE OR PRINT) <u>James JOSEPH madej</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>3-2-85</u>			2b. HOUR <u>12:34 PM</u>			
3 SEX <u>male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>5-8-18</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>66</u> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City MD</u>			
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>South Baltimore General</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>IRON WORKER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>DRYDOCK</u>	
13a. STATE <u>MD</u>		13b. COUNTY <u>BALTO.</u>		13c. CITY OR TOWN <u>BALTO.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>1514 Fibert ST. 21226</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>John madej</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>— — —</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>218-03-2089</u>		17. INFORMANT ADDRESS <u>LOUISE MADEJ SAME AS 13e</u>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Exhaustion / Infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION <u>3-2-85</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>— P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-21-19-85</u> to <u>3-2-19-85</u> , that (I) (we) last saw the deceased alive on <u>3-2-19-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Sharon Richards, MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3-2-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Gehlent</u>				22e. ADDRESS <u>South Baltimore General</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>3/5/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEMETERY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BROOKLYN AA MD</u>	
24. FUNERAL DIRECTOR NAME <u>GEORGE J GONCE</u>				BALTO MD ADDRESS <u>4001 RITCHIE HWY</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 4 1985</u>	
				25b. REGISTRAR'S SIGNATURE <u>Sharon Richards</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) J Albert Magee			2a. DATE OF DEATH MONTH DAY YEAR 3 5 85		2b. HOUR 9:30 P.M.
1. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 4 15 16		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unknown	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND	13b. COUNTY CARROLL	13c. CITY OR TOWN TANEYTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 409 Red Tulip Court 21787	
14. FATHER'S NAME FIRST MIDDLE LAST John NMI Magee			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETTA NMI PRYTON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) unknown WWII		16b. SOCIAL SECURITY NO. 200-85-2578 9-16-3500	17. INFORMANT ADDRESS ORRIG. LYNCH 102 PASTORIAL BUILD. PRINCE FRED. MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute nonlymphocytic leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>hepatic failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yr
19a. DATE OF OPERATION 0	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/29/85</u> , 19 <u>85</u> , to <u>3/5</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/5/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Barbara A. Conley MD		DEGREE MD		22c. DATE SIGNED 3/5/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARBARA A. CONLEY MD		22e. ADDRESS UMCC 225 Greene St Balt Md			
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL	23b. DATE 3-9-85	23c. NAME OF CEMETERY OR CREMATORY BETHEL BRETHREN CEM	23d. LOCATION CITY OR TOWN FAYETTE Co Pa.	23e. DATE REC'D. BY REGISTRAR MAR 8 1985	
24. FUNERAL DIRECTOR NAME CAPITOL FUN. SER. FALLS CHURCH VA		25. REGISTRAR'S SIGNATURE Graham Gordon			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be completed and filed in by the funeral director, page 3, and 2, and 3, and 4, and 5, and 6, and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, 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and 887, and 888, and 889, and 890, and 891, and 892, and 893, and 894, and 895, and 896, and 897, and 898, and 899, and 900, and 901, and 902, and 903, and 904, and 905, and 906, and 907, and 908, and 909, and 910, and 911, and 912, and 913, and 914, and 915, and 916, and 917, and 918, and 919, and 920, and 921, and 922, and 923, and 924, and 925, and 926, and 927, and 928, and 929, and 930, and 931, and 932, and 933, and 934, and 935, and 936, and 937, and 938, and 939, and 940, and 941, and 942, and 943, and 944, and 945, and 946, and 947, and 948, and 949, and 950, and 951, and 952, and 953, and 954, and 955, and 956, and 957, and 958, and 959, and 960, and 961, and 962, and 963, and 964, and 965, and 966, and 967, and 968, and 969, and 970, and 971, and 972, and 973, and 974, and 975, and 976, and 977, and 978, and 979, and 980, and 981, and 982, and 983, and 984, and 985, and 986, and 987, and 988, and 989, and 990, and 991, and 992, and 993, and 994, and 995, and 996, and 997, and 998, and 999, and 1000.

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ILSE ANNA MAJSTOROVIC</b>			2a DATE OF DEATH MONTH DAY YEAR <b>MARCH 5, 1985</b>		2b HOUR <b>5:30 AM</b>
3 SEX <b>FEMALE</b>	4 RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 16 1922</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GERMANY</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Home Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DRUG STORE</b>
13a STATE <b>MARYLAND</b>					
13b COUNTY <b>ANNE ARUNDEL</b>		13c CITY OR TOWN <b>LAUREL</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wilhelm BAUMGARTEN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA E. DREYER</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>N/A</b>		17 INFORMANT <b>MILOVAN MAJSTOROVIC SAME AS 13c</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CANCER</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CANCER OF THE PANCREAS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (the hospital) attended the deceased from <b>MARCH 4</b> , 19 <b>85</b> , to <b>MARCH 5</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>MARCH 5</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I did) (I did not) view the body after death.					
22b SIGNATURE <b>A. R. Nazemi M.D.</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/5/85</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. R. NAZEMI M.D.</b>		22e ADDRESS <b>CHURCH HOSPITAL</b> <b>100 NORTH BROADWAY</b> <b>21231</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>3/8/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALT. WASH CREMATORY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>LAUREL PG MD</b>					
24 FUNERAL DIRECTOR NAME <b>FLECK FUNERAL HOME INC.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Townsend-Randall</b>	
ADDRESS <b>7601 SANDY SPRING Rd LAUREL</b>					

MEDICAL CERTIFICATION

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W. A. T. H. J.



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FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 3 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MILDRED Elizabeth MALEHORN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 23 85</b>			2b. HOUR <b>11 54</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 19, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (IF WORKING LIFE) <b>Manufacturers Representative</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Display</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Philip Joseph Trueschler</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Cecelia Carey</b>			16. STREET ADDRESS / ZIP CODE <b>8316 Nunley Rd. 21234</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-22-7195</b>		17. INFORMANT ADDRESS <b>Thomas F. Lowe Great Falls, Va. 22066</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Liver failure, Unknown etiology</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 min</b> <b>8 mos</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>									
19a. DATE OF OPERATION <b></b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b></b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>				
22a. I certify that (this hospital) attended the deceased from <b>MARCH 9</b> , 19 <b>85</b> , to <b>MARCH 23</b> , 19 <b>85</b> , that (I) <del>was</del> lost saw the deceased alive on <b>MARCH 23</b> , 19 <b>85</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>am</del> (did) <del>not</del> view the body after death.									
22b. SIGNATURE <b>Susan M. Yeomans</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/23/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUSAN M. YEOMANS</b>			22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/27/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Overlea, Balto. Co., Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc., Balto., Md. 21212</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 28 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical certificate must be filed with the State Dept. of Health and Mental Hygiene.

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BALTIMORE CITY

UNION MEMORIAL HOSPITAL

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 3 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph T MALINOWSKI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>march 17, 1985</b>			2b. HOUR <b>3:30 AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>03-19-96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wyman Park Health Services</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Male Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ship Yard</b>	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4312 Sheldon Ave 21206</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Vincent MALINOWSKI</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosalie MAJAKINOWSKI</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1917-1936</b>		17. INFORMANT <b>Stella Malinowski</b>		ADDRESS <b>(SAME)</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Respiratory Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Progressive Respiratory Failure</b>			
DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastatic Colon Ca</b>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Congestive Heart Failure**

19a. DATE OF OPERATION <b>2-11-85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Obstructing Rectal Cancer</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
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22a. I certify that (I) (this hospital) attended the deceased from <b>2-7</b> , 19 <b>85</b> , to <b>3-16-85</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3-16</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
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22b. SIGNATURE <b>MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/16/85</b>	
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Samuel Dwight Lyon</b>		22e. ADDRESS <b>Wyman Park Hospital</b>	
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-20-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Md.</b>	
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24. FUNERAL DIRECTOR <b>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Lina Davidson-Randall</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2009 COLLECTION

1917-1936

1917-1936

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1917-1936

1917-1936

1917-1936

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the next of kin must file the will with the State Dept. of Health and Mental Hygiene.

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Pasadena, Md  
DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>OTTO W. MANNING</b>										20. DATE OF DEATH MONTH <b>3</b> DAY <b>12</b> YEAR <b>85</b>		26. HOUR <b>11:53</b> AM	
3. SEX <b>MALE</b>		4. RACE <b>CAU.</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>3</b> YEAR <b>14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN <b></b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.							
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIV OF MD CANCER CTR</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MARINA ENG</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SHIPPING</b>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>ANNE ARUN.</b> 13c. CITY OR TOWN <b>RIVERA BEACH</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE <b>244 Kenwood Rd 21122</b>									
14. FATHER'S NAME FIRST <b>BENJAMIN</b> MIDDLE <b>A.</b> LAST <b>MANNING</b>				15. MOTHER'S MAIDEN NAME FIRST <b>LOUISE</b> MIDDLE <b>R.</b> LAST <b>Warren</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>230-07-3766</b>		17. INFORMANT <b>AIRI V. MANNING</b>				ADDRESS <b>SAME AS 13E</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE INFERIOR MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SMALL CELL LUNG CANCER &amp; TREATMENT</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PARANEOPLASTIC SYNDROME</b> Related to										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>PARANEOPLASTIC SYNDROME</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>1/15, 19 85</b> , to <b>1/12, 19 85</b> , that (I) (we) lost saw the deceased alive on <b>3/12, 19 85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Carla S. Alexander, MD</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/12/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CARLA S. ALEXANDER, MD</b>						22e. ADDRESS <b>UNIV. OF MD. CANCER CTR</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/15/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem Park</b>		23d. LOCATION CITY OR TOWN <b>Glen Burnie</b> COUNTY <b>A.A.</b> STATE <b>Md</b>							
24. FUNERAL DIRECTOR <b>George J. Gonce 4001 Ritchie Hwy Balto Md</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Carla Davidson-Randall</b>					

3-12-82 11:25

OTTO W. MANNING

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BALTIMORE UNIT OF MD CANCER CTX MARINA ENCL

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BENJAMIN W. MANNING LEASE

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SMALL CELL LINE CANCER # TREATMENT  
PARANEOPLASTIC SYNDROME

RECEIVED

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3/13/82 X  
CANCER & ALEXANDER, MD UNIT OF MD CANCER CTX  
CANCER & ALEXANDER, MD

James W. Manning, Inc.



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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07835

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA DOROTHY MARCINIAK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 21, 1985</b>			2b. HOUR <b>8:50 P.M.</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 22, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE CITY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANCIS SCOTT KEY MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWORK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>322 HORNER ST., 21224</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Stanley Pisarski</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Szymanski</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>217-03-9925</b>		17. INFORMANT <b>GERALD MARCINIAK</b>		ADDRESS <b>322 HORNER ST.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY DECLINE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SUBARACHNOID HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION <b>—</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 18, 1985</b> , to <b>MARCH 21, 1985</b> , that (I) (we) last saw the deceased alive on <b>MARCH 21, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/21/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John Harter</b>			22e. ADDRESS <b>FRANCIS SCOTT KEY MEDICAL CENTER BALTIMORE, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-25-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Charles S. Zeiler &amp; Son Inc.</b>					ADDRESS <b>6224 Eastern Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 25 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rosa --- MAROCCO			2a. DATE OF DEATH MONTH DAY YEAR March 17, 1985		2b. HOUR 12:30AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 28, 1896		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 309 Kernway 21212		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -----				
13a. STATE Maryland		13b. COUNTY -----		13c. CITY OR TOWN Baltimore		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 309 Kernway 21212				
14. FATHER'S NAME FIRST MIDDLE LAST Joseph D'Ercole			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Verdecchia			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Baltimore, Md. Josephine Lazzati 311 Kernway 21212		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>cardio respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic cardiovascular disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Obesity</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/66</u> , 19 <u>85</u> , to <u>3/17</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/28/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>John R. Davis, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Mar 19, 85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Davis, M.D.		22e. ADDRESS Medical Arts Building Baltimore, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE Mar 20, 85		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.		24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc. 7110 Belair Road Baltimore, Md. 21206				
25a. DATE REC'D. BY REGISTRAR MAR 19 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson Henderson</u>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Elizabeth E. Marquard			2a. DATE OF DEATH MONTH DAY YEAR March 22 1985			2b. HOUR A. 8:15 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 25 1887		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garden Village Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 139 N. Ellwood Ave. 21205	
14. FATHER'S NAME FIRST MIDDLE LAST George Sipple Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Easley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 216-28-4120		17. INFORMANT ADDRESS 3635 Erdman Ave. George Marquard (son) 21213			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a DEMENTIA									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. David Zajano					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-22-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. David Zajano					22e. ADDRESS Franklin Square-Medical Arts Room 205				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/25/85		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR'S NAME Schimunek Funeral Home Inc. 3331 Brehms Ln Balto. Md. 21213					25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE C. E. Anderson		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>HARRY C. MARSE Sr.</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>3 18 85</i>		2b. HOUR <i>6:25 PM</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 1, 1914</i>	
6. AGE (IN YEARS (LAST BIRTHDAY)) <i>71</i> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE</i> MD.			
10. CITY OR TOWN OF DEATH <i>BALTIMORE CITY</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>UNION MEMORIAL HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Standard Oil Co.</i>	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>Md.</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>2824 Grindon Avenue 21214</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Lee Marse</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Myers</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>		16b. SOCIAL SECURITY NO. <i>220-07-4706A</i>		17. INFORMANT ADDRESS <i>Mrs. Mary J. Marse Same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>inferior myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Right Ventricle infarct</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/17</i> 19 <i>85</i> , to <i>3/18</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3/18</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Robert Joel Vising</i>		DEGREE <i>M.P.</i>		22c. DATE SIGNED <i>3/18/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert Joel Vising</i>		22e. ADDRESS <i>UNION MEMORIAL HOSPITAL</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>Mar. 20, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westview London Park</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md.</i>		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Leonard J. Ruck Inc. Baltimore, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Car Davidson-Randall</i>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary MARGARET Martin</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3-20-85</i>		2b. HOUR <i>11:28 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 27 13</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>72</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Baltimore General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>worked with spray paint</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>factory</i>	
13a. STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Baltimore</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <i>5221 6th St, Baltimore md 21228</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Alvie ----- Wyatt</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie ----- Gours</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>220249653</i>	
17. INFORMANT <i>Jessie Rey (daughter)</i>		18. ADDRESS <i>1627 Lytle Ct, Baltimore md</i>		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure - Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Infarct</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3-17-1985</i> to <i>3-20-1985</i> , that (I) we lost saw the deceased alive on above, (I) we did (did not) view the body after death.							
22b. SIGNATURE <i>Malinda H. White</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3-20-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Malinda H. White</i>		22e. ADDRESS <i>South Baltimore General Hospital, Baltimore</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial Removal</i>		23b. DATE <i>Mar. 24, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Maplewood Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Ches West Virginia</i>	
24. FUNERAL DIRECTOR <i>M. Cully Funeral Home</i>		ADDRESS <i>Balto Md. 21230 130 E. First Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 27 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Anderson-Monahan</i>	

092034

A

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00000



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Rena Martin			2a. DATE OF DEATH MONTH DAY YEAR March 31, 1985		2b. HOUR M.
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 21 42		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4408 Manorview Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4408 Manor View Rd. 21229	
14. FATHER'S NAME FIRST MIDDLE LAST Carl Johnson	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrdis Coleman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
16b. SOCIAL SECURITY NO. 217-38-3955		17. INFORMANT ADDRESS Veronica Lewis 1302 Mantle Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Cervical Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>STAGE IB Cervical Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>242 yrs.</u> <u>17 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1984</u> to <u>April 85</u> , that (I) (we) lost saw the deceased alive on <u>JAN-24</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Ross C. Donahower</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-2-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROSS C. DONAHOWER		22e. ADDRESS Johns Hopkins Onc. Ctr.			
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 4/6/85	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, County Md.	
24. FUNERAL DIRECTOR NAME C. March F/H 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR APR 3 - 1985			
		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>ELIZABETH</u> <u>B</u> <u>MASON</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>Mar</u> <u>3</u> <u>85</u>		2b. HOUR <u>3:21 A.M.</u>					
3. SEX <u>FEMALE</u>		4 RACE <u>BLACK</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>01</u> <u>01</u> <u>09</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>76</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Calvert Co. Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE, City</u> MD.				
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>UNIVERSITY OF MD</u>				12a. USUAL OCCUPATION (IF NOT WORKING, GIVE REASON) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u>			13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>532 CHATEAU AVE</u> <u>21212</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>William</u> <u>I</u> <u>BROWN</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>BROOKS</u> <u>EVA</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>220-14-8597</u>		17. INFORMANT <u>Edell Brown</u>		ADDRESS <u>3624 REISTERSTOWN RD.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Colon Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>years</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CONGESTIVE HEART FAILURE</u>										
19a. DATE OF OPERATION <u>3/83</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Colon Cancer</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>3 MARCH</u> 19 <u>85</u> , to <u>3 MARCH</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE <u>J. T. Schwartz Jr</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>3 MARCH 85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. T. SCHWARTZ JR</u>				22e. ADDRESS <u>22 SO. GRANE ST.</u>						
23a. BURIAL, CREMATION, REMOVAL (CHECK) <u>BURIAL</u>		23b. DATE <u>3-9-85</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Arbutus Memorial</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE</u> <u>Co.</u> <u>Md.</u>				
24. FUNERAL DIRECTOR NAME <u>Joseph L. Russ</u>				ADDRESS <u>2222 W. North Ave.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 6 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>		

RECEIVED

ADDITIONAL NOTICES

NOTICE OF THE  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE



10-10-45

MAY 10 1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 4 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>George Lewis Mason</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 4, 1985</b>			2b. HOUR <b>8:10PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 29, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Handyman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Varied</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2020 Maryland Avenue</b> <b>21218</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Royal J. Mason</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada May Pullen</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT <b>Self - 1977</b>		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Gastrointestinal Bleed</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 28, 1985</b> to <b>March 4, 1985</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>March 4, 1985</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did not) see the body after death.									
22b. SIGNATURE <b>Jeffrey G. Hite M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/4/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeffrey G. Hite M.D.</b>				22e. ADDRESS <b>C/O Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/8/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Veterans</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Garrison Forest, Balto., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Stewart &amp; Mowen Co.</b>				ADDRESS <b>108 W. North Ave. 21201</b>		DATE REC'D. BY REGISTRAR <b>MAR 11 1985</b> REGISTRAR'S SIGNATURE <b>Julia E. [Signature]</b>			

BP **12**



11-11-1944

079125

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 07843

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ELLA NICHOLSON MATHENY		2a. DATE OF DEATH MONTH DAY YEAR 03-12-85		2b. HOUR 10:45 A.M.	
3. SEX FEMALE	4 RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 01-21-12		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MEAT PACKER	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM J. NICHOLSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA LEE FORREST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 223-03-9553		17. INFORMANT ADDRESS JOHN C. MATHENY 3121 NORTHWAY DR. 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic ovarian carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>gangrene left foot</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one year</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>gangrene left foot</u>					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/9</u> 19 <u>85</u> to <u>3/12</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/12</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>E. Bruce</u>		DEGREE MD		22c. DATE SIGNED 3/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVE E. BRUCE		22e. ADDRESS 22 CATON AVE, BALTIMORE 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b. DATE 03-15-85		23c. NAME OF CEMETERY OR CREMATORY FOREST LAWN	
23d. LOCATION CITY OR TOWN RICHMOND		COUNTY VIRGINIA		STATE	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D BY REGISTRAR MAR 15 1985	
25b. REGISTRAR'S SIGNATURE <u>Marshall H. Hurd</u>					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

011103

THE UNIVERSITY OF CHICAGO

CHICAGO, ILLINOIS

YOUNG, JAMES H.

1912-1913

1914-1915

1916-1917

1918-1919

1920-1921

1922-1923

1924-1925

1926-1927

1928-1929

1930-1931

1932-1933

1934-1935

1936-1937

1938-1939

1940-1941

1942-1943



100055

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07844

1. DECEASED NAME (TYPE OR PRINT) <u>BABY</u> <u>GIRL</u> <u>MATHEWS</u>			2a. DATE OF DEATH MONTH <u>3</u> DAY <u>18</u> YEAR <u>85</u>			2b. HOUR <u>5-25P</u> M.				
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>3</u> DAY <u>18</u> YEAR <u>85</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>—</u> YRS. MONTHS <u>—</u> DAYS <u>—</u> HOURS <u>—</u> MIN. <u>—</u>		7. IF UNDER 1 YEAR <u>—</u> IF UNDER 24 HRS. <u>—</u>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALT. city</u> MD.				
10. CITY OR TOWN OF DEATH <u>BALT</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>ST. AGNES HOSP</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>N/A</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>MD.</u> COUNTY <u>BALTO.</u>			13b. CITY OR TOWN <u>BALTO.</u>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <u>1310 S. Carey St. 21230</u>			
14. FATHER'S NAME FIRST <u>DANIEL</u> MIDDLE <u>J.</u> LAST <u>MATHEWS</u>			15. MOTHER'S MAIDEN NAME FIRST <u>LAVIOLETTE</u> MIDDLE <u>C</u> LAST <u>PECOR</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>N/A</u>			16b. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT ADDRESS <u>Daniel J. Matthews Same as # 13</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>7651</u> IMMEDIATE CAUSE (a) <u>IMMATURITY - 20 weeks</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>1 hr 25 min</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>—</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/18/85</u> 19 <u>85</u> to <u>3/18/85</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/18/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Nikhil Dave MD</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/18/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>NIKHIL DAVE</u>			22e. ADDRESS <u>ST. AGNES HOSP, BALT, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>4/4/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u>Md.</u> STATE <u>Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Witzke Fun'l Home, 1630 Edmondson Ave.</u>					25a. DATE REC'D. BY REGISTRAR <u>APR 8 1985</u>		25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Herbert Mathis</b>				2a. DATE OF DEATH MONTH <b>3</b> DAY <b>7</b> YEAR <b>84</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>15</b> YEAR <b>00</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS. <input checked="" type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City Md.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Trees</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Tree Trimming</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Balt. City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>216 S. Smallwood St. 21223</b>		14. FATHER'S NAME FIRST <b>John</b> MIDDLE LAST <b>Mathis</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Cobbie</b> MIDDLE LAST <b>Hobbs</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>218-14-2633</b>		17. INFORMANT ADDRESS <b>Mrs. Corrie Mathis Baltimore, MD 21223</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>CARDIOVASCULAR ARREST</b> IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CARCINOMA LUNG.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PNEUMONIA</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>PNEUMONIA</b>							
19a. DATE OF OPERATION <b>NA</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>NA NA 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>NA</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>NA</b>		21f. LOCATION STREET <b>ORA</b> CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-7-85</b> , 19 <b>85</b> , to <b>3-7-85</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3-7-85</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Sign Anka</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/7/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SURJIT JUCKA</b>				22e. ADDRESS <b>Bon Secours Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-11-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Seals Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Damascus</b> COUNTY <b>Montgomery</b> STATE <b>MD</b>	
24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b> ADDRESS <b>Lysaorth, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1985</b> 25b. REGISTRAR'S SIGNATURE <b>Gina Gordon</b>			

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074072

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 07846

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GERTRUDE K. MATTHEWS</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>11</b> YEAR <b>85</b>			2b. HOUR <b>2:00</b> P.M.					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>07</b> YEAR <b>28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 2 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Edgewood N. H.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>116 Hopkins Road 21212</b>			
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b>Wolfert</b> LAST <b>Kouwenhoven</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Alice</b> MIDDLE <b>---</b> LAST <b>Witherell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT <b>Mr. T.C. Matthews</b>		ADDRESS <b>116 Hopkins Road 21212</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Seizure disorder</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Multiple meningioma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Parkinson's Disease</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) this hospital attended the deceased from <b>April</b> , 19 <b>84</b> , to <b>March</b> , 19 <b>85</b> , that (2) (we) last saw the deceased alive on <b>March 9<sup>th</sup></b> , 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (3) we (did) did not view the body after death.											
22b. SIGNATURE <b>Christine K. Hernandez</b> MD						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/11/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Christine K. Hernandez</b>						22e. ADDRESS <b>11722 Reisterstown Rd</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-13-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION CITY OR TOWN <b>Baltimore City</b> COUNTY STATE <b>Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 York Road 21212</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Christine K. Hernandez</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02/10/72

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074062

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

07347

FOR  
1- STATE  
REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		26. HOUR	
Laverne		Matthews						3/ 12/19 85								M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		21. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		24. HOUR	
FEMALE	BLACK	6 26 63	21	MONTHS		DAYS		3/ 12/19 85								8:18	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
BALTO., Md.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City,										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
BALTO. Baltimore		205 Amity St.															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		205 AMITY ST. APT. #7									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
JAMES		MATTHEWS				ANNIE		GOLDER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		217-84-3008		ANNIE MATTHEWS		438 MANSE CT. 21201											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Intravenous Narcotism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)		DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 3/12/85									
ACTUAL SIGNATURE		EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St.											
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
BURIAL		3/16/85		MT. AUBURN CEM.		BALTO., Md.											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
LEROY O. DYETT 4600		MAR 13 1985		J. H. Davidson													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

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DMW - WINTER



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WEBSTER HARRISON MAYES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 10 85</b>		2b. HOUR <b>6:03A M</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>04 26 11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2508 MARBOURNE AVENUE, 21230</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AUTO MECHANIC</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AUTO DEALERSHIP</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN D. MAYES</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>OLIE CULLUM</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>218-05-9088</b>		
17. INFORMANT <b>DAVID W. MAYES</b>			ADDRESS <b>2508 MARBOURNE AVENUE, 21230</b>		

18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

**INTRACTABLE CONGESTIVE HEART FAILURE**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Conditions, if any, which  
gave rise to immediate  
cause 18a, stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

**PREVIOUS MYOCARDIAL INFARCTIONS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

**CORONARY ARTERY DISEASE**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 18c.

MEDICAL CERTIFICATION

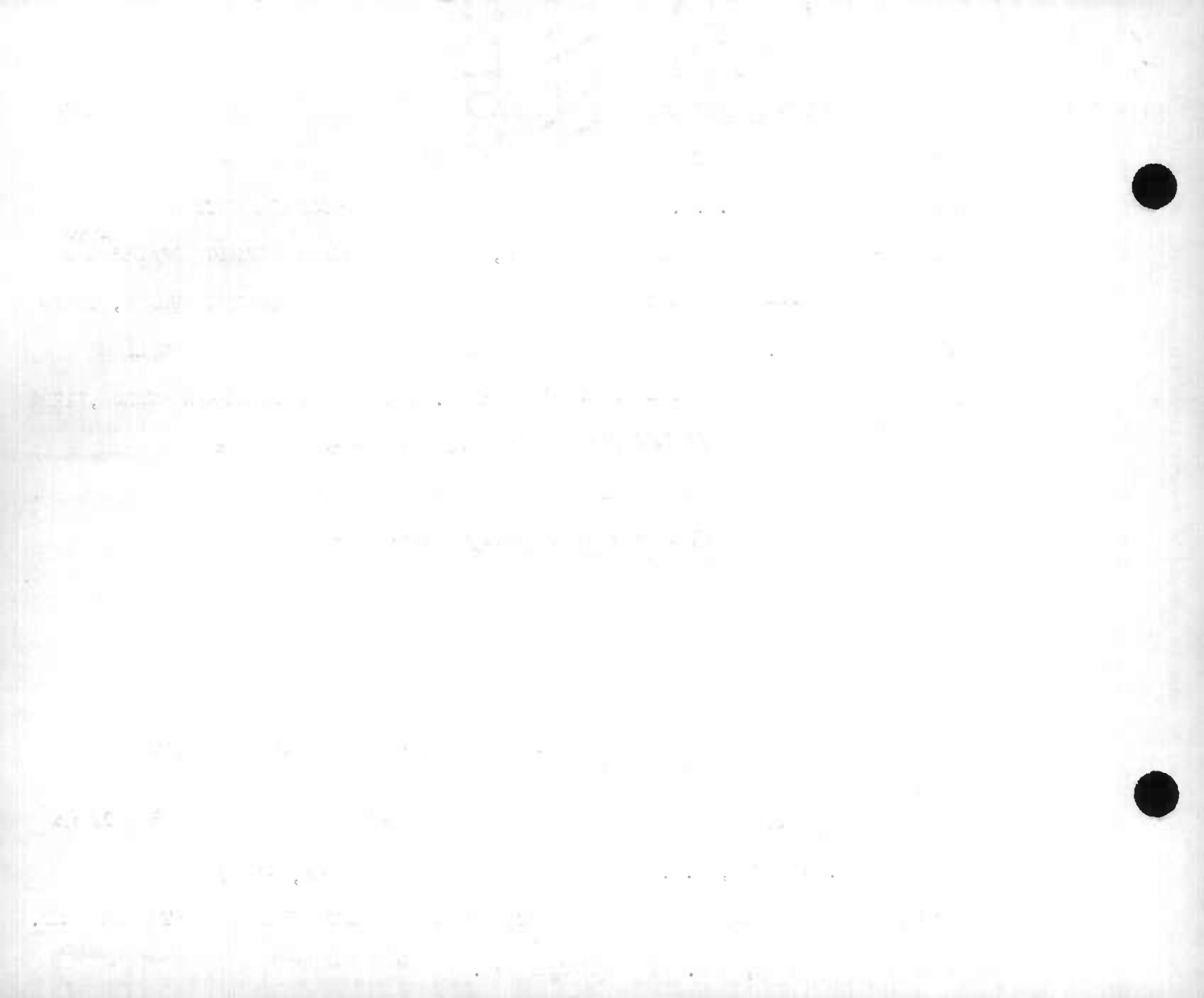
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>April 19 69</b> to <b>Mar 19 85</b> , that (I) (we) lost saw the deceased alive on <b>Feb 23 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Eugenio E. Benitez</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>3/12/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EUGENIO E. BENITEZ, M.D.</b>		22e. ADDRESS <b>3455 WILKENS AVENUE, 21229</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>	23b. DATE <b>03-12-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SECURITY PROCESS</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>CATONSVILLE BALTIMORE MD.</b>
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>		21229 ADDRESS <b>4107 WILKENS AVE.</b>	25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1985</b>
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



078063

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edith L. McCleary			2a. DATE OF DEATH MONTH DAY YEAR 3-17-85			2b. HOUR 6 A M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-15-1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4502 Mannasota Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Seamstress		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4502 Mannasota Ave. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-05-3621		17. INFORMANT ADDRESS Howard D. McCleary, Same as 13e					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic DUE TO, OR AS A CONSEQUENCE OF (c) Cardiovascular disease		20 yrs.	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Generalized Body edema including pulmonary edema							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from OCT 19 86 to MAR. 17 19 85, that (I) (we) lost the deceased alive on MAR 16 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Albert C. Herrmann, M.D.				DEGREE M.D.		22c. DATE SIGNED 3/18/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert C. Herrmann, M.D.				22e. ADDRESS 5525 Belair Rd.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Westview		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd.				25a. DATE REC'D. BY REGISTRAR MAR 18 1985		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Organization

Division

Office

Mr. ...

Mr. ...

3/18/64

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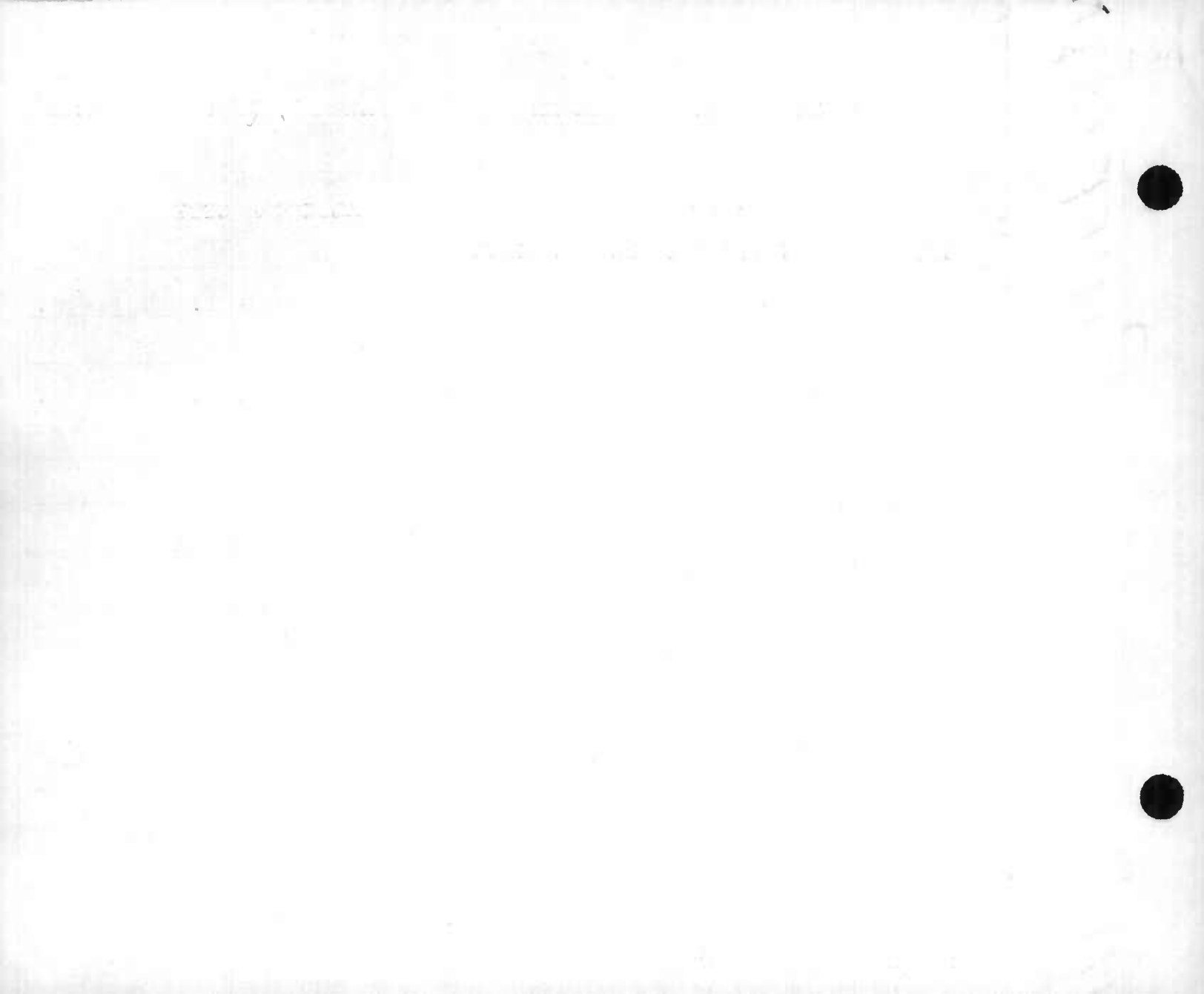
081322

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										8 5 0 7 8 5 0	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BRIAN B. MCCONE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 1, 1985</b>			2b. HOUR P <b>1:15 M</b>			
3. SEX <b>MALE</b>		4. RACE <b>EURASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 20, 1982</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>2</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>COLUMBIA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>9318 MATADOR RD. COLUMBIA MD. 21045</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>GARY McCONE</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PHUONG-ANH BUI</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-----</b>		17. INFORMANT ADDRESS <b>GARY McCONE 9318 MATADOR RD. COLUMBIA MD. 21045</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Cor pulmonale</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe bronchopulmonary dysplasia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>1 day</b> <b>2 years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Seizure</b>											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> , 19 <b>85</b> , to <b>3/1</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/1/85</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Joe Kaempf</b>		DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/1/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOE KAEMPF</b>				22e. ADDRESS <b>JHH WOLFE ST BALTO MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/6/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CREST LAWN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>MARRIOTTSTVILLE MARYLAND</b>					
24. FUNERAL DIRECTOR <b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOME OF COLUMBIA</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>			
5555 TWIN KNOLLS ROAD COLUMBIA MARYLAND 21045											



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF IT CAN BE AT IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
GEORGE		T.		McCORD				2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY	
Male		White		Sept. 7 1912		72 YRS.		MONTHS		DAYS		HOURS		MIN.		7.00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Louisiana				U.S.A.								Baltimore City					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore				4320 Clareway Apt. 7H				Truck Driver				WT Cowan					
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?					
Maryland				-----				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.					
George Washington McCord				Margaret Kegel				no				216-10-7376					
17. INFORMANT				ADDRESS				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Norman McCord				5 Colonial Court				PART 1 DEATH WAS CAUSED BY:									
								IMMEDIATE CAUSE (a) Smoke and soot inhalation and thermal injury									
								DUE TO, OR AS A CONSEQUENCE OF									
								(b)									
								DUE TO, OR AS A CONSEQUENCE OF									
								(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?									
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				3-3-85				caught in housefire									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
				home				4320 Clareway Apt. 7H				Baltimore, Maryland					
22a. I certify that I took charge of the remains described above, held an				Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
Margarita A. Korell, M.D.				Assistant				3-4-85									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Margarita A. Korell, M.D.				111 Penn Street													
23a. BURIAL CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
1 Burial				Mar. 5 1985				Oak Lawn Cemetery				Baltimore Md.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Lilly & Zeiler, Inc.				MAR 11 1985				John Davidson									

027307

CHINA  
MARITIME  
COTTON



1967

1 - FOR  
STATE  
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
John M. McCormick					3 6 85					525 PM	
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		Feb. 8, 1927		58		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Baltimore City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		South Balto. Gen. Hosp. Balto. Md.				Drug Co. Shipping & Receiving					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1735 S. Hanover St. Balto. Md.		21230	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Matthew J. McCormick		Evelyn Ruby									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		216-24-8997		Mr. James F. McCormick		1424 Forest Park Ave. Balto. Md. 21207					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Brain death											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Meningitis											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION					
		HOUR A.M. MONTH DAY YEAR		P.M. 19		STREET CITY OR TOWN COUNTY STATE					
21e. INJURY OCCURRED		21f. PLACE OF INJURY		21g. LOCATION		STREET CITY OR TOWN COUNTY STATE					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		AT WORK							
22. I certify that (I) (this hospital) attended the deceased from 2/4, 1985, to 3/6, 1985, that (I) (we) last saw the deceased alive on 3/6, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23a. SIGNATURE						DEGREE		23c. DATE SIGNED			
James F. McCormick						MD					
23b. PHYSICIAN'S NAME (TYPE OR PRINT)						23d. ADDRESS					
James F. McCormick						3001 S. Hanover St. Balto.					
23a. BURIAL, CREMATION, REMOVAL (CHECK)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		March 11, 1985		Holy Cross Cemt.		Baltimore,		Maryland			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.						MAD 0 1005		Davidson-Randall			



Handwritten text, possibly a signature or initials, oriented vertically.

Handwritten text, possibly a signature or initials, oriented vertically.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 5 3

REG. NO.

1. FOR  
STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Beth McCormick

2a. DATE OF DEATH MONTH DAY YEAR  
03 06 852b. HOUR 15  
1A

3. SEX

F

4. RACE

Cauc

5. DATE OF BIRTH

MONTH DAY YEAR  
12 05 03

6. AGE (IN YEARS LAST BIRTHDAY)

81

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Balto. City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Sinai Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Operator

12b. KIND OF BUSINESS OR INDUSTRY

Phone

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Md.

13b. COUNTY

13c. CITY OR TOWN  
Balto.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

3900 N. Charles St.

21218

14. FATHER'S NAME

Charles

MIDDLE

H.

EAST

Keefer

15. MOTHER'S MAIDEN NAME

Susan

MIDDLE

Thompson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

214-03-2854

17. INFORMANT

Mr. Robert McCormick Balto., Md.

ADDRESS

3900 N. Chas. St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Carcinoma of lung-metastatic

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Perforated gastric ulcer

19a. DATE OF OPERATION

1/30/85

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

Perforated gastric ulcer

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 30, 19 85, to March 6, 19 85, that (I) (we) lost

saw the deceased alive on March 6, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Rhonda Fiskel MD

DEGREE

ATTENDING

PHYSICIAN ☐

MEDICAL

DIRECTOR ☐

STAFF

PHYSICIAN ☒

22c. DATE SIGNED

3/6/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Rhonda Fiskel MD

22e. ADDRESS

Sinai Hospital of Baltimore

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Removal

23b. DATE

3/6/85

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Anatomy Board

ADDRESS

Balto., Md.

25a. DATE REC'D. BY REGISTRAR

MAR 11 1985

25b. REGISTRAR'S SIGNATURE

John Davidson-Randall

BP

106179

35

42

35

100

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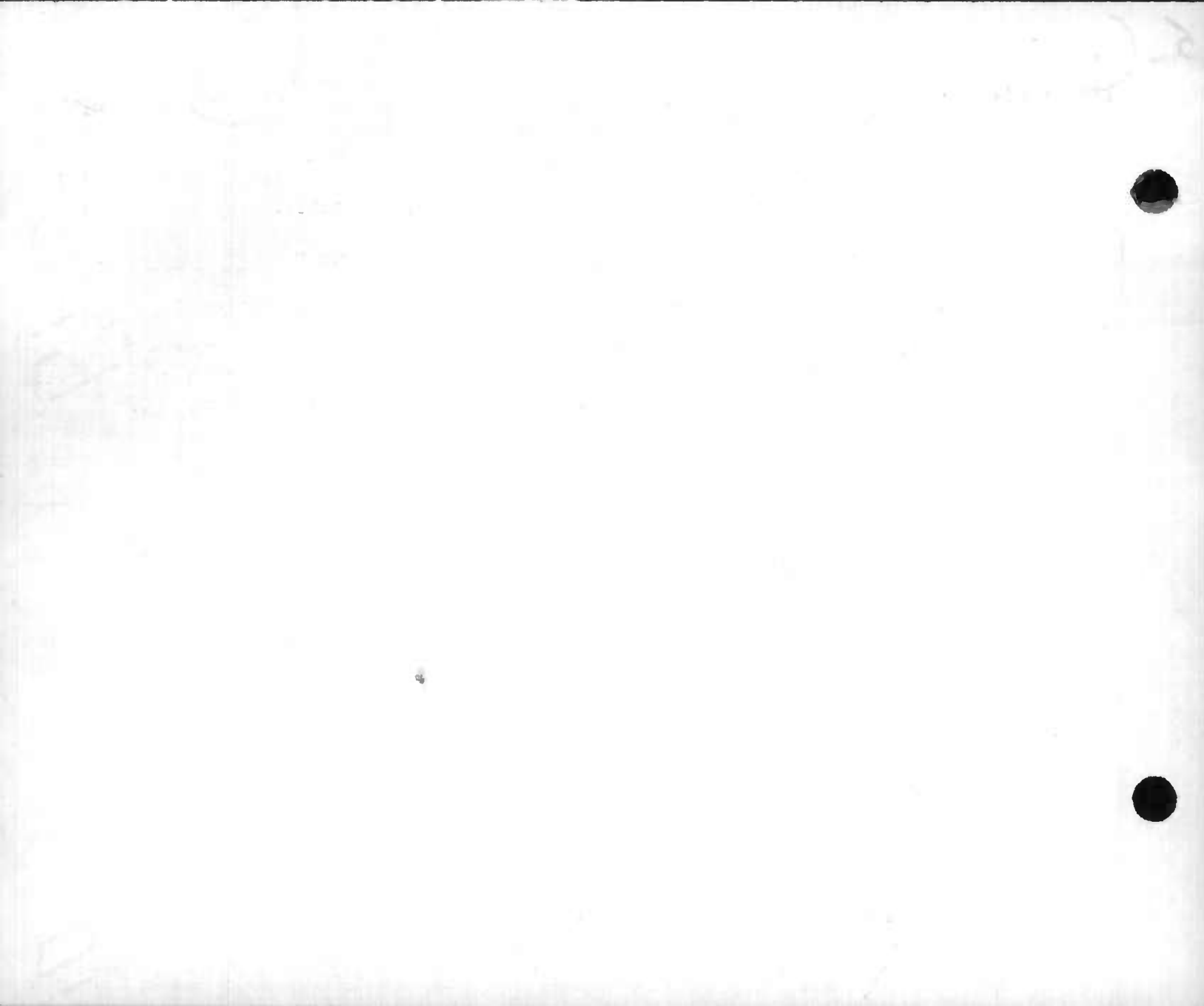
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

092058

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary McCrady			2a. DATE OF DEATH MONTH DAY YEAR 3 24 85		2b. HOUR 9:24 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 12 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Misty Harbor	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7620 Ross Road 21219	
14. FATHER'S NAME FIRST MIDDLE LAST Casawell M. Taylor				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna E. Walker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 228-30-7361		17. INFORMANT Betty H. Kirschner				ADDRESS Same as 13e	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) cardiovascular event

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) abdominal catastrophe

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

severe COPD, ischemic heart disease.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> , 19 <u>85</u> , to <u>3/24</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/24</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
27b. SIGNATURE <u>Brenda W. Cooper</u>		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				27c. DATE SIGNED 3/25/85	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Brenda W. Cooper		27e. ADDRESS Francis Scott Key Medical Center					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/28/1985		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, Maryland 21222				25a. DATE REC'D. BY REGISTRAR MAR 28 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

098087

PAUL MCCRAW II, M  
03/22/85

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85507855

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAUL V MCCRAW II		2a. DATE OF DEATH MONTH DAY YEAR MARCH 28, 1985	
3. SEX male		2b. HOUR 11:45 PM	
4. RACE Col.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HRS. MIN. YRS. 6	
5. DATE OF BIRTH MONTH DAY YEAR 3-22-85		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
7a. BIRTHPLACE Baltimore, Md.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BALTIMORE		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BABY	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 922 N. Central Ave. 21202	
13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. FATHER'S NAME FIRST MIDDLE LAST Paul McCraw Sr.	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Harden		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Paul McCraw 922 N. Central Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Low CARDIAC OUTPUT DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5 days		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0-25 min.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION 3/28/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Congenital Heart Defects	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/28/85 to 3/28/85, that (I) (we) last saw the deceased alive on 3/28/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE G. J. Magovern		22c. DATE SIGNED 3/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAGOVERN		22e. ADDRESS 600 N WOLFE ST BALTO, MD. 21205	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-2-85	
23c. NAME OF CEMETERY OR CREMATORY Balto. Nat Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME Joseph L. Russ		25a. DATE REC'D. BY REGISTRAR APR 2 - 1985	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

RELEASED NON-MED DR. KORELL PER MR. LAWYER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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LIBRARY

074084

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 5 0 7 8 5 6

1- FOR  
STATE  
REGISTRAR

Bertrice J. McDade CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Bertrice J. McDade</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 11 95</b>			2b. HOUR <b>4:45 P.M.</b>			
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8-22-18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>422 Bighy Ave. 21227</b>			14 FATHER'S NAME FIRST MIDDLE LAST <b>John 1 Wooden</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lilly Jones</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16a. SOCIAL SECURITY # <b>408-34-6724</b>		17 INFORMANT ADDRESS <b>Vivian Morcek (daughter) 422 Bighy Ave</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cervical Carcinoma</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. <b>Recent Myocardial Infarction</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (a) (this hospital) attended the deceased from <b>3/13</b> 19 <b>85</b> , to <b>3/11</b> 19 <b>85</b> , that (a) (we) lost saw the deceased alive on <b>3/11</b> 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert J. Moss</b>			DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3-11-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert J. Moss</b>			22e. ADDRESS <b>3001 South Hanover St</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>3/13/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		
24 FUNERAL DIRECTOR NAME <b>Schimunek Funeral Home, Inc.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>		
24b. ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5858.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 8 57

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>CARRIE A. (E) MCEACHERN</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>85</b>			2b. HOUR <b>3:05 P.M.</b>				
3 SEX <b>F</b>		4 RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>19</b> YEAR <b>31</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIV. OF MARYLAND HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b></b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>21201</b> <b>124 W. Franklin St. Apt. 215</b>	
14 FATHER'S NAME FIRST <b>Johnny</b> MIDDLE <b></b> LAST <b>McNair</b>				15 MOTHER'S MAIDEN NAME FIRST <b>Sadie</b> MIDDLE <b>Johnson</b> LAST <b>Carter</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>251-62-3883</b>		17. INFORMANT ADDRESS <b>Flossie Weeden 1722 Presbury Street</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROLONGED HYPOTENSION</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) <b>BLEEDING</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>RECURRENT CERVICAL CARCINOMA</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>19</b> , to <b>19</b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>C. L. Mullins M.D.</b> DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/5/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. L. Mullins, M.D.</b>						22e. ADDRESS <b>22 S. Greene St. Baltimore Md.</b>				
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>			23b. DATE <b>3/13/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Johns Hopkins - 1651</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Jake Davidson-Randall</b>		

BP

Photo



2021 COLLECTION

WINTER 2021

Check for the 2021 Collection

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07858			
1. DECEASED NAME (TYPE OR PRINT) <b>CLARA M. McFADDEN</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>3-3-85</b>		2b. HOUR <b>19</b>		2c. DATE PRONOUNCED DEAD <b>3-3-85</b>		2d. HOUR <b>1:23P</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>15</b> YEAR <b>17</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>67</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		7c. DATE PRONOUNCED DEAD <b>3-3-85</b>		7d. HOUR <b>1:23P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>111 Centre St. Apt. 1501</b>		21201			
14. FATHER'S NAME FIRST <b>Ed</b> MIDDLE <b></b> LAST <b>Evans</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Easter</b> MIDDLE <b></b> LAST <b>Kingwood</b>				ADDRESS <b>Apt. 304</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>248-40-0122</b>		17. INFORMANT <b>Dorothy Norman</b>				ADDRESS <b>4724 Wakefield Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE OF UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>Margaret A. Korell</b>				M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>3-4-85</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>				23b. DATE <b>3/9/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>				23d. LOCATION CITY OR TOWN <b>Randallstown,</b> COUNTY <b>MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b> ADDRESS <b>1101 E North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

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MAR 17 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 5 9

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
WILBERT		D		MCGEE		SR.		03		03	85	1:00PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
MALE		WHITE		MARCH 9, 1922		62		MONTHS		DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
W. VA.		USA				BALTIMORE CITY MD								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												
BALTIMORE		THE JOHNS HOPKINS HOSPITAL												
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY												
TERMINAL MGR.		TRUCKING												
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
MARYLAND				BALTIMORE		HALETHORPE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1123 MEADOWLARK DR. 21227				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				ADDRESS						
CHARLES MC GEE				MARY ARNOLD										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT						
YES				WW2				Mrs. Anne McGee 1123 MEADOWLARK DRIVE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>												5 MINUTES		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>METABOLIC ENCEPHALOPATHY</u>												4 DAYS		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>HEPATIC LYMPHOMA</u>												1 MONTH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
				HOUR A.M. MONTH DAY YEAR										
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION						
WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				HOMELAND, STREET, FACTORY, OFFICE, FARM, ETC.)				CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) entered the deceased from above, (I) (we) (did) (did not) enter the body after death.														
22b. SIGNATURE				DEGREE				22c. DATE SIGNED						
CARLOS DEL RIO				MD				MARCH 3, 1985						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS										
CARLOS DEL RIO				JHH 600 N. Wolfe St. Balto. MD 21205										
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION		
BURIAL				3/07/85				MEADOWRIDGE CEMETERY				DORSEY HOWARD MARYLAND		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
NAME ADDRESS				MAR 6 1985				J. Davidson-Randall						
AMBROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD														

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or duly-licensed funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove card 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be given to the funeral director. It should be detached for use on the burial transit permit. Then please reattach certificate to page 1 and 2 and return to the hospital after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/8  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 6 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUTH L. MCGHEE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAR. 10, 1984</b>		2b. HOUR <b>7:28A<sub>M</sub></b>			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-10-1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>64</b> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BOOK KEEPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BANK</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD.</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT S. UNDERWOOD</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GRACE ELLINGTON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>239-18-6439</b>		17. INFORMANT ADDRESS <b>Mr. James R. McGhee - 2309 E. Madison St. 21205</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic obstructive pulmonary disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>3 months</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Cerebrovascular accident</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <b>3/1</b> , 19 <b>85</b> , to <b>3/10</b> , 19 <b>85</b> , that (1) (we) lost saw the deceased alive on <b>3/10</b> , 19 <b>85</b> , and that in my(our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.								
22b. SIGNATURE <b>John Humphries</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/10/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John Humphries</b>				22e. ADDRESS <b>Johns Hopkins Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3-13-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK GROVE CHURCH CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HIGHPOINT N.C.</b>		
24. FUNERAL DIRECTOR NAME <b>John D. Hill</b>				24b. ADDRESS <b>2334 Jefferson St.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1985</b>		
				25b. REGISTRAR'S SIGNATURE <b>John D. Hill</b>				

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14-10-1950

U.S.A.

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BOOKKEEPER  
JACK E. HANSON  
ST. LOUIS

ST. LOUIS

Mr.

ROBERT S. UNDERHILL

ST. LOUIS

ST. LOUIS, MO. - JACK E. HANSON, BOOKKEEPER

Re

ST. LOUIS, MO. - JACK E. HANSON, BOOKKEEPER

ST. LOUIS, MO. - JACK E. HANSON, BOOKKEEPER



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8507861	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NORMA Lee MCGOWAN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 25, 1985</b>			2b. HOUR <b>3:30 A</b>			
3. SEX <b>Female</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT 7 1952</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>32</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.			
7b. BIRTHPLACE (STATE OR FOREIGN) <b>A.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Billing Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>A.A.C.O</b>			
13a. STATE <b>MD</b>					13b. CITY OR TOWN <b>ANNAPOLIS</b>		13c. STREET ADDRESS / ZIP CODE <b>10 Melrose Court 21401</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK MCGOWAN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH Edna HALL</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>217-58-0289</b>		17. INFORMANT ADDRESS <b>FRANK MCGOWAN 7 Morris ST ANNAPOLIS</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MULTI ORGAN system Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEPSIS</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mins</b> <b>2 wks</b> <b>3 wks</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic Myelogenous Leukemia undergoing bone marrow transplant</b>											
19a. DATE OF OPERATION <b>3/25</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>2/29</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2 12 85</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>JOHNS HOPKINS HOSPITAL ANNAPOLIS A.A. MD</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/25</b> 19 <b>85</b> , to <b>3/25</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/25</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Charles J. Duffy MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/25/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles J. Duffy</b>						22e. ADDRESS <b>Johns Hopkins Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3-29-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILLcrest</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ANNAPOLIS A.A. MD</b>				
24. FUNERAL DIRECTOR NAME <b>C.E. Hicks III</b>						ADDRESS <b>1922 Forest Drive ANNAPOLIS</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 29 1985</b>			
						25b. REGISTRAR'S SIGNATURE <b>Julien Davidson</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN, The following is required: that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be furnished for use as the burial/transfer permit. Then please return the certificate, page 4, to the funeral director. Page 4 should be buried with the deceased.  
The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

10/10/10  
001300

DECEMBER 10

10/10/10  
10/10/10



THE END OF THE WORLD

THE END OF THE WORLD  
THE END OF THE WORLD

081930

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 6 2

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Frances V. McGuire</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 14 85</i>			2b. HOUR <i>8:44</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 12 12</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS.		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MINS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Baltimore General Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home Maker</i>		
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>505 Washburn Avenue 21225</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Norval W. McCarty</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Bell Brooks</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR (UNKNOWN)) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>215-09-4800</i>		17. INFORMANT ADDRESS <i>Md 21225</i>		17. INFORMANT ADDRESS <i>William McGuire 510 Alden Street, Balto</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Acute Myocardial Infarction</i>									
DUE TO, OR AS A CONSEQUENCE OF: (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <i>3/14 19 85</i>		21f. LOCATION CITY OR TOWN <i>3/14 85</i>		21f. LOCATION COUNTY STATE <i>85</i>	
22a. I certify that (I) this hospital attended the deceased from <i>3/14</i> 19 <i>85</i> to <i>3/14</i> 19 <i>85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>H. Feng M.D.</i> DEGREE						22c. DATE SIGNED <i>3/14/85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H. FENG, M.D.</i>						22e. ADDRESS <i>SBC&amp;H.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/18/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cem.</i>		23d. LOCATION CITY OR TOWN <i>Balto</i>		23d. LOCATION COUNTY STATE <i>A.A. Md</i>	
24. FUNERAL DIRECTOR <i>George J. Gonce 4001 Ritchie Hwy Balto Md</i>						25a. DATE REC'D. BY REGISTRAR <i>MAK 20 1985</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

081030

RECEIVED  
FEB 10 1964

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
[illegible]

RE: [illegible]  
[illegible]

[illegible]

20% COTTON



20% COTTON

[illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
THEODORE P. McHUGH		03 18 85		10 09 AM	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
MARE	CAUCASIAN	MONTH DAY YEAR	76 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
FLORIDA	U.S.		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE CITY	UNIVERSITY HOSPITAL		UNKNOWN		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	BALT. CITY	BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1418 Reynolds ST 21230	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
WILLIAM McHUGH		MARY TAYLOR			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
UNKNOWN		265-09-1244		Mr. McHugh 1418 Reynolds St. 21230	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY Arrest DUE TO, OR AS A CONSEQUENCE OF (b) POST OP RESPIRATORY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
11/7/85		ZENKERS DIVERTICULUM		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
		P.M.			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22a. I certify that (I) (this hospital) attended the deceased from 11/7/85 to 3/18/85 that (I) (we) last saw the deceased alive on 3/18/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
DEBRA A. VACHON		MD		3/18/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DEBRA A. VACHON		UNIVERSITY HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (CHECK)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
CREMATION	3/19/85	WINTER CEM.	615 W. HATFIELD AVE. MD. 21238		
24. FUNERAL DIRECTOR (NAME)		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles S. Stevens Funeral Home, Inc.		MAR 19 1985		[Signature]	

BP

10. TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

20% COLLECTED

WIKI

Handwritten notes and signatures, including "Theodore P. ...", "1912", and "X".



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8507864

1 - FOR  
STATE  
REGISTRAR

REG. NO.

093141

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANASTASIA C. MCKENNA				2a. DATE OF DEATH MONTH DAY YEAR 03 30 85		2b. HOUR 3:30 PM	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 22 1905		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER		12b. KIND OF BUSINESS OR INDUSTRY BON SECOURS HOSP.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY		13c. CITY OR TOWN BALTIMORE	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN MCKENNA				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE HEALY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-24-7156		17 INFORMANT ADDRESS SR. CLARE MCKENNA 524 North Charles St. 21201			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic carcinoma of lung, unknown primary</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/28</u> 19 <u>85</u> to <u>3/30</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/30</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death.							
22b. SIGNATURE Morian St Martin				22c. DATE SIGNED 3/30/85		22d. ADDRESS Mercy Hospital Balto.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/2/85		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALTIMORE	
24 FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229				25a. DATE REC'D. BY REGISTRAR APR 1 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION



11000



Handwritten notes or signatures, possibly indicating a date or location.

081335

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

07868

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
BERNARD V. McLAIN				3. 9. 85		1.35 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE		WHITE		MONTH DAY YEAR 10 12 1905		79 YRS.		MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH		12. IF UNDER 24 HRS	
Maryland		U.S.A.				Baltimore City, MD			
13. CITY OR TOWN OF DEATH		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		15a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Mercy Hospital		Ret. B&O R.R. Truck Driver					
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		17. CITY OR TOWN		18. INSIDE CITY LIMITS?		19. STREET ADDRESS / ZIP CODE			
13a. STATE		13b. COUNTY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3227 Hiss Ave. 21234			
Maryland		Baltimore							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
Francis		E. McLain		Minnie		Wambach			
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		20. SOCIAL SECURITY NO.		21. INFORMANT		22. ADDRESS			
No		705-09-2925		Mrs. Bernardine Moran		Same as # 13e			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebrovascular accident

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 day

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Respiratory distress, probable aspiration

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 9, 1985</u> to <u>March 9, 1985</u> , that (I) (we) last saw the deceased alive on <u>March 9, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Christine J. Bell-Lafferan</u>		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTINE J BELL-LAFFERAN MD		22e. ADDRESS MERCY HOSPITAL 301 ST PAUL'S PLACE BALT MD					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		3/13/85		Loudon Park		Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc.		MAR 11 1985		<u>John Ruck</u>			
ADDRESS		Baltimore, Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a series of lines or a list.]

0 5 0 7 8 6 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Mary H. McMaster</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>March 17, 1985</i>		2b. HOUR M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7-3-1903</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. City</i>		8. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>		10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>6412 Rosemont Avenue</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>B &amp; O RR</i>		13. STREET ADDRESS / ZIP CODE <i>6412 Rosemont Avenue-21206</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William H. Howard</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Victoria Buckmaster</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>	
17. SOCIAL SECURITY NO. <i>705-09-1444</i>		18. INFORMANT ADDRESS <i>Mr. Douglas R. McMaster 6412 Rosemont Ave.</i>		19. DATE OF OPERATION <i>3/13/85</i>	
20. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Angiographic Intracranial Aneurysm</i>		21. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		25. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
26. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		27. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.) <i>170 E. No. Perry Blvd. Baltimore</i>		28. LOCATION STREET CITY OR TOWN COUNTY STATE <i>170 E. No. Perry Blvd. Baltimore</i>	
29. I certify that (I) (this hospital) attended the deceased from <i>10/3/27</i> 19 <i>19</i> , to <i>3/17/85</i> 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>3/13/85</i> 19 <i>85</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.		30. SIGNATURE <i>W. M. Smith</i>		31. DATE SIGNED <i>3/19/85</i>	
32. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. M. Smith</i>		33. ADDRESS <i>170 E. No. Perry Blvd. Baltimore</i>		34. DATE REC'D. BY REGISTRAR <i>MAR 20 1985</i>	
35. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		36. DATE <i>3-21-85</i>		37. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	
38. FUNERAL DIRECTOR NAME <i>John C. Miller Inc-6415 Belair Rd.-21206</i>		39. ADDRESS <i>6415 Belair Rd.-21206</i>		40. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

MD

REG. NO.

088068

1. DECEASED NAME (TYPE OR PRINT) Dorothy McPherson			2a. DATE OF DEATH MONTH DAY YEAR 3 22 85			2b. HOUR 405 P M		
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 3 14 05	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.					
10. CITY OR TOWN OF DEATH Balt City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balt. Gen. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD			13b. CITY OR TOWN Balt	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 150 Carver Rd 21222		
14. FATHER'S NAME Jesse			15. MOTHER'S MAIDEN NAME Hattie Shaw					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 218-22-5644			17. INFORMANT Address A Charles McPherson 150 Carver Road		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

Renal insufficiency

DUE TO, OR AS A CONSEQUENCE OF

(c)

Respiratory insufficiency

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Feb 12, 19 85, to March 22, 19 85, that (I) (we) lost saw the deceased alive on March 22, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul Wang MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Warsawsky / Khandewal		22e. ADDRESS South Balt. Gen Hospital					

23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL	23b. DATE 3/28/85	23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk	23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR MAR 26 1985	
		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of other death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02862





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
JOHN		CARBRY		MEAGHER				3		6		19		85		M	
1. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	3-25-34		50 YRS.						3		6		19		85	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH								MD.	
Maryland		U.S.A.		WIDOWED		DIVORCED		Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		University Hospital STU		Driver		Trucking											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Baltimore		Parkville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2 Ranger Ct. 21234									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
John		Francis		Meagher		Gertrude		Kane									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		Korea		218-30-5429		Miss Lisa Meagher		2 Ranger Ct. 21234									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Gunshot wound of head		Weapon: Handgun		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
						DUE TO, OR AS A CONSEQUENCE OF											
						DUE TO, OR AS A CONSEQUENCE OF											
						DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		7:58 PM 3/5 1985		self inflicted gunshot wound													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
		home		2 Ranger Ct, Pikesville, Balto Co, MD													
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
Dennis F. Smyth, M.D.		Assistant				3/6/85											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Dennis F. Smyth, M.D.		111 Penn Street, Baltimore, MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		3-11-85		Garrison Forrest VA		Owings Mills Baltimore Maryland											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Mitchell-Wiedefeld Home		6500 York Road 21212				MAR 8 1985		P. R. ...									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LUCILLE REBECCA MEDLEY			2a. DATE OF DEATH MONTH DAY YEAR 3 19 85			2b. HOUR 12 <sup>30</sup> M					
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 2 18		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 842 Evesham Ave. 21212		
14. FATHER'S NAME FIRST MIDDLE LAST Belvin Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McLean							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 228-12-8387		17. INFORMANT ADDRESS Shirley Crowder 842 Evesham Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>brain mass</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>uterine / abdominal CA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>3/8</u> , 19 <u>85</u> , to <u>3/19</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/19</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>MD McLean</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3-19-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. VILLANI				22e. ADDRESS union memorial hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/24/85		23c. NAME OF CEMETERY OR CREMATORY Family Plot			23d. LOCATION CITY OR TOWN COUNTY STATE Sanford N.C.			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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MEMO

CONFIDENTIAL

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CONFIDENTIAL

TO  
FROM  
SUBJECT

094145

5/21/85 Item #13 L.J

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 7 0

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>MEISENBACH</u> <u>BG</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>3-1-85</u>			2b. HOUR <u>5:37</u> PM	
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>3-1-85</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>034</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sinai Hosp</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>infant</u>		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE (TYPE OR PRINT) CITY OR TOWN <u>MD</u> <u>Baltimore</u>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <u>12 Queenbridge Court 21030</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Meisenbach</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Meisenbach</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <u>NO</u>		16b. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT ADDRESS <u>Meisenbach</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) extreme immaturity

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) presumed chorioamnionitis

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. — 19 —		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — — — 19 —		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — —			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1-85</u> , 19 <u>85</u> , to <u>3-1</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3-1</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William G. Keyes</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>3-1-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WILLIAM G. KEYES</u>				22e. ADDRESS —			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>3-10-85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sinai Hospital</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Sinai Hospital</u>		ADDRESS <u>Sinai Hospital</u>		25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE) <u>MAR 27 1985</u> <u>John Davidson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Jim		MIDDLE Melvin		LAST		2a. DATE KNOWN OF DEATH ESTI. <input checked="" type="checkbox"/> MATED <input type="checkbox"/>		MONTH 3		DAY 20		YEAR 1985		2b. HOUR M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 1, 1917		6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 20 1985		2d. HOUR 12:22					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City											
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2524 E. Hoffman Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Self Employed											
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2524 E. Hoffman St. 21213									
14. FATHER'S NAME FIRST MIDDLE LAST John		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mazie Mc Clain		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 242-58-2559		17. INFORMANT Lucille Melvin		ADDRESS 2524 E. Hoffman St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Margareta McKell</u>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 3/20/85											
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, MD.		ADDRESS 111 Penn St, Balto., MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-25-85		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cmty.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. Md.											
24. FUNERAL DIRECTOR NAME Randolph J. Collick		ADDRESS 2431 E. Oliver St.		25a. DATE REC'D. BY REGISTRAR MAR 22 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randell											

07/84  
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DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REASONS SHOULD BE STATED. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 7 2

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE CORRECT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST <b>BLANCHE WORTHINGTON MERTZ</b>			MONTH DAY YEAR <b>3 10 85</b>			HOUR <b>5 24 PM</b>		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
<b>FEMALE</b>	<b>WHITE</b>	MONTH DAY YEAR <b>07 07 1885</b>	<b>99</b> YRS			MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. BALTIMORE CITY OR COUNTY OF DEATH	10. CITY OR TOWN OF DEATH						
<b>MARYLAND</b>	<b>BALTIMORE CITY</b> MD	<b>BALTIMORE</b>						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<b>SOUTH BALTIMORE GENERAL HOSPITAL</b>		<b>HOMEMAKER</b>			<b>---</b>			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE	
<b>MARYLAND</b>	<b>---</b>	<b>BALTIMORE</b>	<b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	<b>4900 STAFFORD STREET APT. 2</b> <b>21229</b>				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST <b>JAMES W. PACA</b>			FIRST MIDDLE LAST <b>MARY E. HOBBS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
<b>NO</b>			<b>219-28-9053</b>			<b>CHARLOTTE EICHELBERGER 132 GARDEN RIDGE RD. 21228</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Septic shock</b>								
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Septic shock</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Septic shock</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>Dem. to</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR <b>19</b>					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <b>3/8</b> , 19 <b>85</b> , to <b>3/10</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/10</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<b>Harvey E. Lyndee Jr.</b>			<b>MD</b>			<b>3/10/85</b>		
22d. PHYSICIAN'S NAME (TYPE CORRECT)			22e. ADDRESS					
<b>Harvey E. Lyndee Jr.</b>			<b>3001 S. Howard St.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
<b>BURIAL</b>			<b>03-13-85</b>			<b>CEDAR HILL</b>		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>			<b>MAR 12 1985</b>			<b>Wardson-Randall</b>		

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

05 07873

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE BELT LAST MILES			2a. DATE OF DEATH MONTH DAY YEAR MAR 26 1985		2b. HOUR 3:40 P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Keswick Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD 13b. COUNTY		13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3838 Roland Avenue, 21211
14. FATHER'S NAME FIRST MIDDLE LAST Osborn Belt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia Royston			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215 54 2078	17. INFORMANT ADDRESS Mrs. Gordon Hoffman, Balto., MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 26 Dec 19 79 to 26 MAR 19 85, that (I) (we) last saw the deceased alive on 26 MAR 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (did not) view the body after death.					
22b. SIGNATURE Aubrey D. Richardson M.D.		DEGREE M.D.		22c. DATE SIGNED 26 MAR 1985	
22d. PHYSICIAN'S NAME (PRINT) Aubrey D. Richardson M.D.		22e. ADDRESS 700 W. 40th St. Balto Md 21211			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/27/85	23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212			25a. DATE REC'D. BY REGISTRAR MAR 28 1985		25b. REGISTRAR'S SIGNATURE Randall

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Mr. Gordon Hoffman, Baltimore, Md.

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Henry W. Jenkins & Sons Co.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE IN PRINT) FIRST MIDDLE LAST <i>Edith Mae Miller</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 4 85</i>			2b. HOUR <i>4 23 P.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 19 26</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>58</i>		7. UNDER 1 YEAR MONTHS DAYS <i>YRS.</i>	
8. BIRTHPLACE (STATE OR FOREIGN) <i>Maryland</i>		9. CITIZEN OF WHAT COUNTRY? <i>USA</i>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
12. CITY OR TOWN OF DEATH <i>Baltimore</i>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Baltimore Senior</i>				14. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>22 E. Heath St. Balto. Md. 21230</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Bennie --- Webster</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sadie --- Shores</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-22-2671</i>		17. INFORMANT ADDRESS <i>Severn, Md. 21144</i> <i>Mr. Albert C. Miller, 3rd. 7870 Locustwood Rd.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypoxia Brain death</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardiac arrest</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/10/1985</i> to <i>3/4/1985</i> , that (I) (we) last saw the deceased alive on <i>3/4/1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE <i>Harry E. Hyndes</i>						DEGREE <i>MD</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Harry E. Hyndes</i>						22e. ADDRESS <i>3001 S Hanover St</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Mar. 7, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Park</i>		23d. LOCATION (CITY OR TOWN, COUNTY, STATE) <i>Elkridge, Howard Co. Md.</i>		
24. FUNERAL DIRECTOR NAME <i>McGilly Funeral Home, 130 E. 1st Ave. Balto. Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>MAR 5 1985</i>		25b. REGISTRAR'S SIGNATURE <i>J. L. Davidson-Rodell</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 showing any injury, or other traumatic event, the medical examiner must be notified at once.

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Vertical text or markings on the right side, possibly a list or index.



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07875

1. DECEASED NAME (TYPE OR PRINT) <b>FAYE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 / 12 / 1985</b>			2b. HOUR <b>6 43 A.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 27 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>XXXXXX</b>		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7010 SURREY DRIVE #21215</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>LOUIS ISMART</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JENNIE UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT <b>MR. SAMUEL MILLER</b> <b>7010 SURREY DR. BALTO., MD 21215</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Adenocarcinoma Unknown primary &amp; pulmonary involvement</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>And a CAS involvement</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>INSULIN Dependent Diabetes Mellitus</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/2/1985</b> , 19 <b>85</b> , to <b>3/12/1985</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/11/1985</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>R. BREM</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>3/12/1985</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>MAR. 13, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MIKRO KODESH-BETH ISRAEL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Jeha Davidson-Randall</b>	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07876	
1. DECEASED NAME (TYPE OR PRINT) <b>Howard F. Miller</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>3</b> DAY <b>23</b> YEAR <b>85</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Jan.</b> DAY <b>11</b> YEAR <b>1938</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>47</b> YRS.		7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>		2b. HOUR <b>8:09</b> a <b>a</b> M <b>M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Crane Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth.Stee</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6576 St. Helena Ave. 21222</b>			
14. FATHER'S NAME FIRST <b>Fred</b> MIDDLE <b>Miller</b> LAST <b>Miller</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Victoria</b> MIDDLE <b>Sheppard</b> LAST <b>Sheppard</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		(IF YES, GIVE WAR OR DATES) <b>1967</b>		16b. SOCIAL SECURITY NO. <b>224-54-8985</b>		17. INFORMANT <b>Georgia Miller (wife)</b>		ADDRESS <b>4115 Brendan Ave. 21213</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>(b) DUE TO, OR AS A CONSEQUENCE OF</b> <b>(c)</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Chronic alcoholism with fatty liver</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Gregory R. Kauffman</b>				M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>3/24/85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>				ADDRESS <b>111 Penn St.</b>				Balto., MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>3/25/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Russell Memorial</b>		23d. LOCATION CITY OR TOWN <b>Lebanon, Va.</b> COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>Schimunek Funeral HOME, Inc.</b> ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 29 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Otto (NMN) Miller								MATED <input checked="" type="checkbox"/> 3 19 85								M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	2-11-1917		67 YRS.						3 19 85						2:57 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Md.		USA				Baltimore City										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		6022 Alta Avenue		Supervisor		Western Elec.											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		-		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6022 Alta Ave. 21206									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Frank Miller		Anna Audolensky															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
yes		WW II		215-10-5337		Alberta Primus (sister)		305 E. Joppa Rd. 21204									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		3/20/85									
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, MD.		ADDRESS		111 Penn Street, Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		3/26/85		Parkwood Cemetery		Baltimore										Md.	
24. FUNERAL HOME NAME		Schimunek Funeral Home, Inc.		ADDRESS		3331 Brehms Lane, Balto. Md. 21213		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
								MAR 26 1985		[Signature]							

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST WILLIAM MILLER		MONTH DAY YEAR MAR. 17, 1985	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
M	W	MONTH DAY YEAR MAY 13 1922	62 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
PA.	USA		BALTO. COUNTY MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
ESSEX	325 LORRAINE		12b. KIND OF BUSINESS OR INDUSTRY BOARD OF ED.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?	13c. STREET ADDRESS
13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD. BALTO. ESSEX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	325 LORRAINE 2124
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)	
ALBERT MILLER		UNK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	
YES		169-162-758	
17. INFORMANT		ADDRESS	
NORMA MILLER		ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) CARDIAC ARREST			
DUE TO, OR AS A CONSEQUENCE OF			
(b) RECURRENT VENTRICULAR TACHYCARDIA 2 weeks			
DUE TO, OR AS A CONSEQUENCE OF			
(c) ASCVD Several yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
MULTIPLE MYELOMA			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 12/14 19 84 to 3/15 19 85, that (we) lost saw the deceased alive above (we) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
JEFFREY M. PARHAM, M.D.		3/19/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
JEFFREY M. PARHAM, M.D.		5518 B PHILADELPHIA RD. BALT. MD. 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
BURIAL		3/20/85	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
MD. VA. GARRISON		BALTO. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	
J.G. CONNELLY 300 MACLE		MAR 19 1985	
		25b. REGISTRAR'S SIGNATURE	
		John H. Anderson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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DATE: 10/10/1911

TO: Mr. J. H. [illegible]

FROM: [illegible]

SUBJECT: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH										2b. HOUR									
Deborah D. Mills																				XX 3-14 19 85										M									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR																									
Female		Black		5 4 58		26 YRS.						3-14 19 85		1:56		M																							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland										U.S.A.																				Baltimore City, MD.									
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore										1136 Whatcoat Street																													
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland																				Baltimore										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1136 Whatcoat St. 21217							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																													
George Mills										DeAnna Alston																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS									
NO										N/A										Rosa C. Miller										915 Parrish Street									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a) Intravenous Narcotism										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
										DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										(b) DUE TO, OR AS A CONSEQUENCE OF																													
										(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																			
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held on death resulted from:										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																													
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																			
Dennis F. Smyth, M.D.										M.D. Assistant MEDICAL EXAMINER										3-14-85																			
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS										111 Penn St., Balto., Md. 21201																			
23a. BURIAL, CREMATION, REMOVAL										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE									
BURIAL										3/18/85										Cedar Hill Cemetery										Anne Arundel Co, Md.									
24. FUNERAL DIRECTOR										25a. DATE REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
Wm C March F/H Inc.										1101 E North Avenue										MAR 15 1985																			

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DHMH - 17  
(VR A15 ME (5))



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PA 3, RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				2b. HOUR			
Minnie P. Mills								DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 27 1985				HOUR 10:26 a M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR	
Female	White	10-14-1925		79 YRS.						MONTH DAY YEAR 3 27 1985				10:26 a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Md.		U.S.A.		Baltimore City, MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		1206 Cleveland Street - 21230				Labor				Paint Co.					
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Md.				Baltimore				1206 Cleveland St. 21230							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
William E. Taylor				Grace E. Summit											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
No				214-03-1376A				Former Fannertiel 21230 A. 206 Cleveland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 3/27/85			
EXAMINER'S NAME (TYPE OR PRINT)				Gregory R. Kauffman, M.D.								ADDRESS 111 Penn St. Balto., MD.			
23a. BURIAL, CREMATION, REMOVAL (TYPE)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				3-29-1985				Cato National Cem.				Baltimore Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
John J. Cowan & Son, Inc.				MAR 29 1985				Julia Davidson							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

087065

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 5 07881	
1. DECEASED NAME (TYPE OR PRINT) <b>Patrick D. Mills</b>										2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>3-20 1985</b>	
3. SEX <b>male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 9 53</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>31 YRS.</b>		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>3-20 1985</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2919 Winchester St. 21216</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Mills</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriett Harris</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <b>Emma Grier 2201 Liberty Heights Av</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound of Head (unspecified)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>3:15 P.M. 3-20 1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject was shot</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1300 blk. Bloomingdale Road, Balto., Md.</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>3-21-85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>3/25/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eastview Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Wm N<sup>CE</sup> March F/H Inc.</b> ADDRESS <b>1101 E North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 22 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Richard R. Rouse</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>DAVID NMN MITCHELL</b>			2a DATE OF DEATH MONTH <b>3</b> DAY <b>12</b> YEAR <b>85</b>			2b HOUR <b>1:30A</b> M						
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH <b>1</b> DAY <b>10</b> YEAR <b>26</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY</b> MD.						
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, BALTIMORE, MD. 21218</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
13a STATE <b>Maryland</b>			13b COUNTY		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE <b>2213 East North Avenue 21213</b>		
14 FATHER'S NAME FIRST <b>Abram</b> MIDDLE <b>Mitchell</b> LAST <b>Mitchell</b>				15 MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Mitchell</b> LAST <b>Mitchell</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b SOCIAL SECURITY NO. <b>228-28-4347</b>			17 INFORMANT ADDRESS <b>Atliea Clark 2733 Ashland Avenue</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aspiration of Gastric Contents</b>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Pancreatic Carcinoma</b>												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2/25</b> , 19 <b>85</b> , to <b>3/12</b> , 19 <b>85</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>3/12</b> , 19 <b>85</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.												
22b SIGNATURE <b>Tim Jack M.D.</b>						DEGREE <b>M.D.</b>			22c DATE SIGNED <b>3/12/85</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Tim Jack M.D.</b>						22e ADDRESS <b>3900 LOCH RAVEN BLVD. BALTIMORE, MD. 21218</b>						
23a BURIAL, CREMATION, REMOVAL <b>BURIAL</b>			23b DATE <b>3/16/85</b>		23c NAME OF CEMETERY OR CREMATORY <b>Md Nat'l Mem Pk.</b>			23d LOCATION CITY OR TOWN <b>Laurel,</b> COUNTY <b>Md.</b> STATE <b>Md.</b>				
24 FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b> ADDRESS <b>1101 E North Avenue</b>						25a RECEIVED BY REGISTRAR 25b REGISTRAR'S SIGNATURE <b>MAR 13 1985</b>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

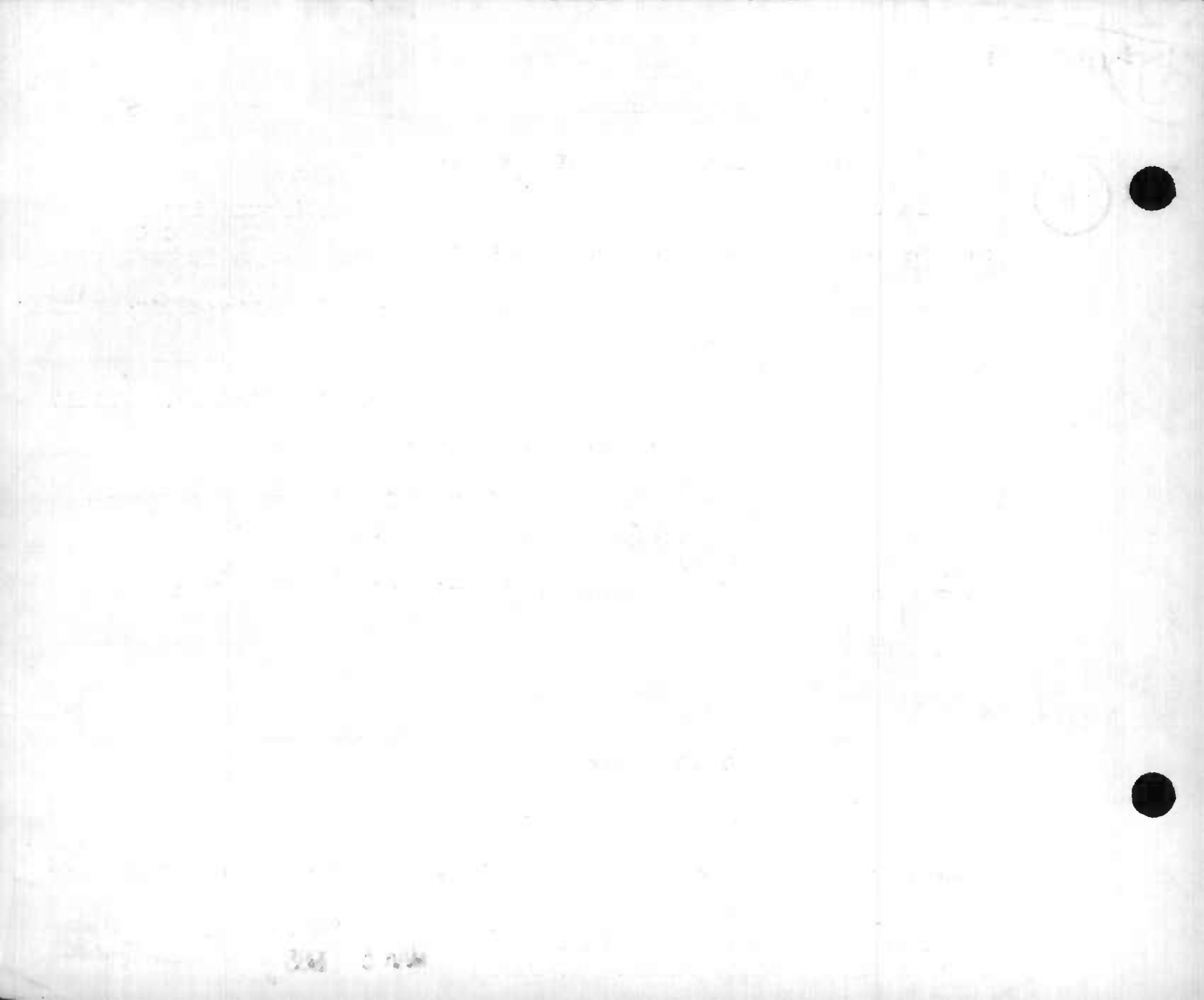
DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 8 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Estelle M. Mitchell			2a. DATE OF DEATH MONTH DAY YEAR 03 01 85		2b. HOUR A. 9.49 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 08 08 14		6. AGE (IN YEARS (LAST BIRTHDAY)) 70 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH BALTO. MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technician		12b. KIND OF BUSINESS OR Research
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 502 N. Lakewood Ave 21203	
14. FATHER'S NAME FIRST MIDDLE LAST Wm. E. Litz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Asher			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-12-5029		17. INFORMANT ADDRESS Robert Roth, 7908 32nd St. 21237	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Severe Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Edema					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. (4) Pulmonary Embolism; Hypertensive Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on 02 27 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE DEGREE Sami A. Brahman, M.D.				22c. DATE SIGNED 21204	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS St. Joseph 7620 York Rd Towson Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/4/85	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.	
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213		25. DATE REC'D. BY REGISTRAR MAR 5 1985			
26. REGISTRAR'S SIGNATURE MURISON RONDALL					



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LILLIAN</b> <b>Mitchell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/14/85</b>		2b. HOUR <b>11:20</b> PM	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 16 1924</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>		12c. ADDRESS / ZIP CODE <b>740 Poplar Grove St. Balto. Md. 21216</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Mitchell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Barnette</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No.</b>		
16b. SOCIAL SECURITY NO. <b>216-20-9035</b>		17. INFORMANT <b>Vernon Mitchell</b>		18. ADDRESS <b>303 Belmont Dr. Cherry Hill, N. J.</b>		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bradycardia - Asystole</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Renal failure, CHF, DM</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>3/14</b> , 19 <b>85</b> to <b>3/14</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/14</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>BICH T DUONG</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/14/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BICH T DUONG</b>		22e. ADDRESS <b>LUTHERAN HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/19/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		
23d. LOCATION CITY OR TOWN <b>Baltimore, Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>MAR 20 1985</b>				
23f. REGISTRAR'S SIGNATURE <b>John Davidson</b>		23g. REGISTRAR'S SIGNATURE <b>John Davidson</b>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. DECEASED NAME				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST				MONTH DAY YEAR				MONTHS DAYS HOURS MIN.			
MARIE J. MITCHELL				March 11, 1985				1:45 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. BALTIMORE CITY OR COUNTY OF DEATH		8. BALTIMORE CITY OR COUNTY OF DEATH	
Female		White		April 24, 1900		84 YRS.		Baltimore City MD.		Baltimore City MD.	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	
MD		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City MD.		Baltimore		500 W. University Parkway	
12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. INSIDE CITY LIMITS?		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Homemaker		Own Home		500 W. University Pkwy.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS	
George J. Peters		Agnes Owens		No		216 44 1162		Mrs. G. Donald Hillary,		Balto., MD	
18. CAUSE OF DEATH		19. CAUSE OF DEATH		20. CAUSE OF DEATH		21. CAUSE OF DEATH		22. CAUSE OF DEATH		23. CAUSE OF DEATH	
PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
Arteriosclerotic cardiovascular disease		Many months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		(IF EITHER, NOTIFY MEDICAL EXAMINER)		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
21a. INJURY OCCURRED		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		P.M. 19									
22a. I certify that (I) (the hospital) attended the deceased from		2-26, 1971, to 3-11, 1985, that (I) (we) lost		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME		22e. ADDRESS	
saw the deceased alive on 3-10, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated				DEGREE		3/11/85		Dr. Alfred G. Ossman, MD		1101 St. Paul Street, Balto., MD	
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME		22e. ADDRESS		22f. BURIAL, CREMATION, REMOVAL		22g. DATE	
Dr. Alfred G. Ossman, MD		3/11/85		Dr. Alfred G. Ossman, MD		1101 St. Paul Street, Balto., MD		Entombment		3/12/85	
22f. BURIAL, CREMATION, REMOVAL		22g. DATE		22h. NAME OF CEMETERY OR CREMATORY		22i. LOCATION		22j. FUNERAL DIRECTOR		22k. DATE REC'D. BY REGISTRAR	
Entombment		3/12/85		Lorraine Mausoleum Balto., MD		CITY OR TOWN COUNTY STATE		Henry W. Jenkins & Sons Co.		MAR 13 1985	
22j. FUNERAL DIRECTOR		22k. DATE REC'D. BY REGISTRAR		22l. REGISTRAR'S SIGNATURE		22m. REGISTRAR'S SIGNATURE		22n. REGISTRAR'S SIGNATURE		22o. REGISTRAR'S SIGNATURE	
4905 York Road Balto., MD 21212		MAR 13 1985		Davidson-Randall		Davidson-Randall		Davidson-Randall		Davidson-Randall	



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From: White

MD USA

Baltimore, E.O. W. University Parkway

MD E.O. W. University Parkway

Charles

1101 E. Paul Street, Baltimore, MD

x

1101 E. Paul Street, Baltimore, MD

MD

Frank W. Jennings & Sons Co.

400 York Road, Baltimore, MD 21201

078126

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 8 6

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
ROBERT L. MITCHELL		03-17-85	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Male	Black	1 13 52	33
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Baltimore City MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Baltimore	Union Memorial Hospital		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE		13b. COUNTY	13c. CITY OR TOWN
Maryland			Baltimore
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Jessie Mitchell		Louise Egglston	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	
NO		N/A	
17. INFORMANT		ADDRESS	
Louise Mitchell		415 E 22 nd Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary collapse + shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable small bowel obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable aspiration pneumonia</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pancreatitis, Probable sepsis, coagulopathy.</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
—		—	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		—	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/13/85</u> , 19 <u>85</u> to <u>3/17</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/17</u> , 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>M. Keith Rawlings</u>		22c. DATE SIGNED <u>3/17/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. Keith Rawlings</u>		22e. ADDRESS <u>Union Memorial Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
BURIAL		3/22/85	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Arbutus Memorial Pk.		Arbutus, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Wm C March F/H Inc. 1101 E North Avenue		MAR 18 1985	
25b. REGISTRAR'S SIGNATURE <u>Wm C March</u>		25c. REGISTRAR'S SIGNATURE <u>Wm C March</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

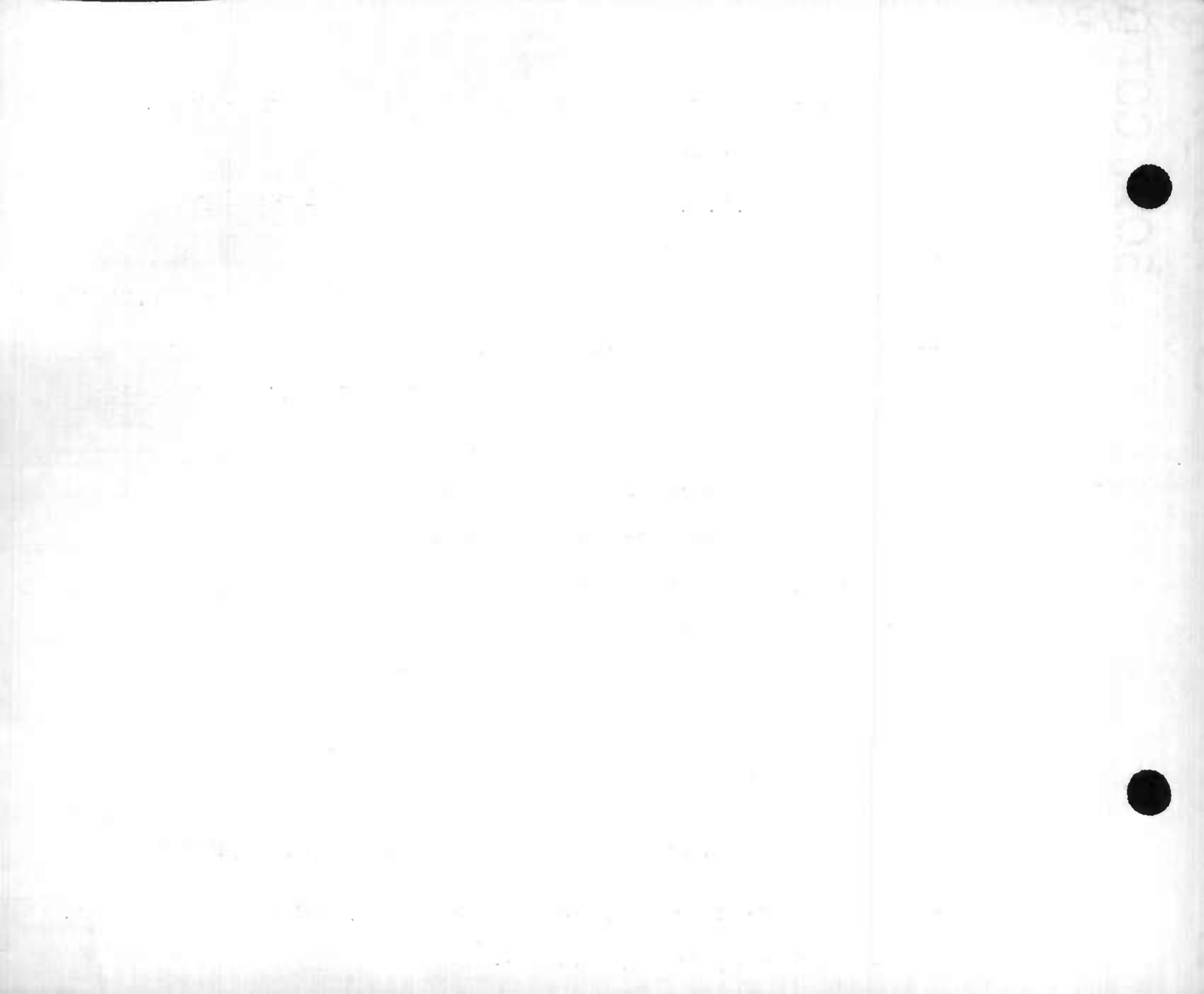
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29

BP



FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 8 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>THEODORE C. MITCHELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 04 85</b>		2b. HOUR <b>4:12 A.M.</b>
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 12, 1936</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Syracuse, N. Y.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Attorney</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY 13c. CITY OR TOWN <b>Md. Baltimore Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>704 Kingston Road 21220</b> <b>21212</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles J. Michalski</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Segal</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>074 28 8944</b>	17. INFORMANT ADDRESS <b>Mrs. Suzanne W. Mitchell 704 Kingston Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>probable sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GI bleed</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>possible CNS bleed, metabolic derangements</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/4</b> 19 <b>85</b> , to <b>3/4</b> 19 <b>85</b> that (I) (we) last saw the deceased alive on <b>3/4</b> 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE <b>Douglas Proops</b>		DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> STAFF <input type="checkbox"/> <b>House</b>	22c. DATE SIGNED <b>3/4/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Douglas Proops</b>		22e. ADDRESS <b>Johns Hopkins 600 N. WOLFE ST. BALTO. MD. 21205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>3/7/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cemetery</b>	23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 6 1985</b>	25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the physician retained by the hospital or attending physician, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be signed by a physician.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 8 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter Mitchell			2a. DATE OF DEATH MONTH DAY YEAR 3-8-85		2b. HOUR 24 P M
3. SEX male	4. RACE col	5. DATE OF BIRTH MONTH DAY YEAR 11-25-1905	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt. Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4316 Manorland Rd		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Short order cook	12b. KIND OF BUSINESS OR INDUSTRY Race track	
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4316 Manorland Rd 21229
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Mitchell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-10-6150	17. INFORMANT ADDRESS MRS EATHRINE RICHARDSON 3116 QUEENSBURY RD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) probable myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): CHF, alcohol abuse, noncompliance, depression					
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (the hospital) attended the deceased from 8/1, 19 84, to 2/20, 19 85, that (the deceased) saw the deceased alive on 2/20, 19 85, and that (my) (my) opinion of death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.)					
22b. SIGNATURE Timothy J. Low		DEGREE MD.		22c. DATE SIGNED 3/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TIMOTHY J. LOW		22e. ADDRESS Md Gen Hosp 827 Linden Ave Balt 21201			
23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL	23b. DATE 3-13-85	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Basilica		23d. LOCATION CITY OR TOWN COUNTY STATE Balt. Co. Md.	
24. FUNERAL DIRECTOR NAME Joseph L. Russ		ADDRESS 2222 W. North Ave.		25a. DATE REC'D. BY REGISTRAR MAR 13 1985	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 8 8 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Zella Elizabeth Mitchell</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 9 85</i>			2b. HOUR <i>3:07 AM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 4 16</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Good Samaritan</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13a. USUAL RESIDENCE 13a. STATE <i>Md</i>		13b. COUNTY <i>XXXXXX</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? <i>X</i> YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>6005 Eunice Ave 21214</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Richard M. Jewens</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Irene S. Jones</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <i>XXXXXX</i>		16b. ADDRESS <i>William Mitchell, 6005 Eunice Ave.</i>		16c. ADDRESS <i>21214</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2 days</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>0</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>March 7, 1985</i> to <i>March 9, 1985</i> , that (I) (we) lost saw the deceased alive on <i>March 9, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John Fan</i>			DEGREE			22c. DATE SIGNED <i>3/9/85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John Fan</i>			22e. ADDRESS <i>Good Samaritan Hospital</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Mar. 12, 1985</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley</i>			
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Timonium, Balto., Md.</i>			23e. DATE REC'D. BY REGISTRAR <i>MAR 11 1985</i>			23f. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>			
24. FUNERAL DIRECTOR <i>ROBERT C. ALTENBURG FUNERAL HOME, INC.</i> <i>6009 Harford Rd., Balto., Md. 21214</i>									

MEDICAL CERTIFICATION

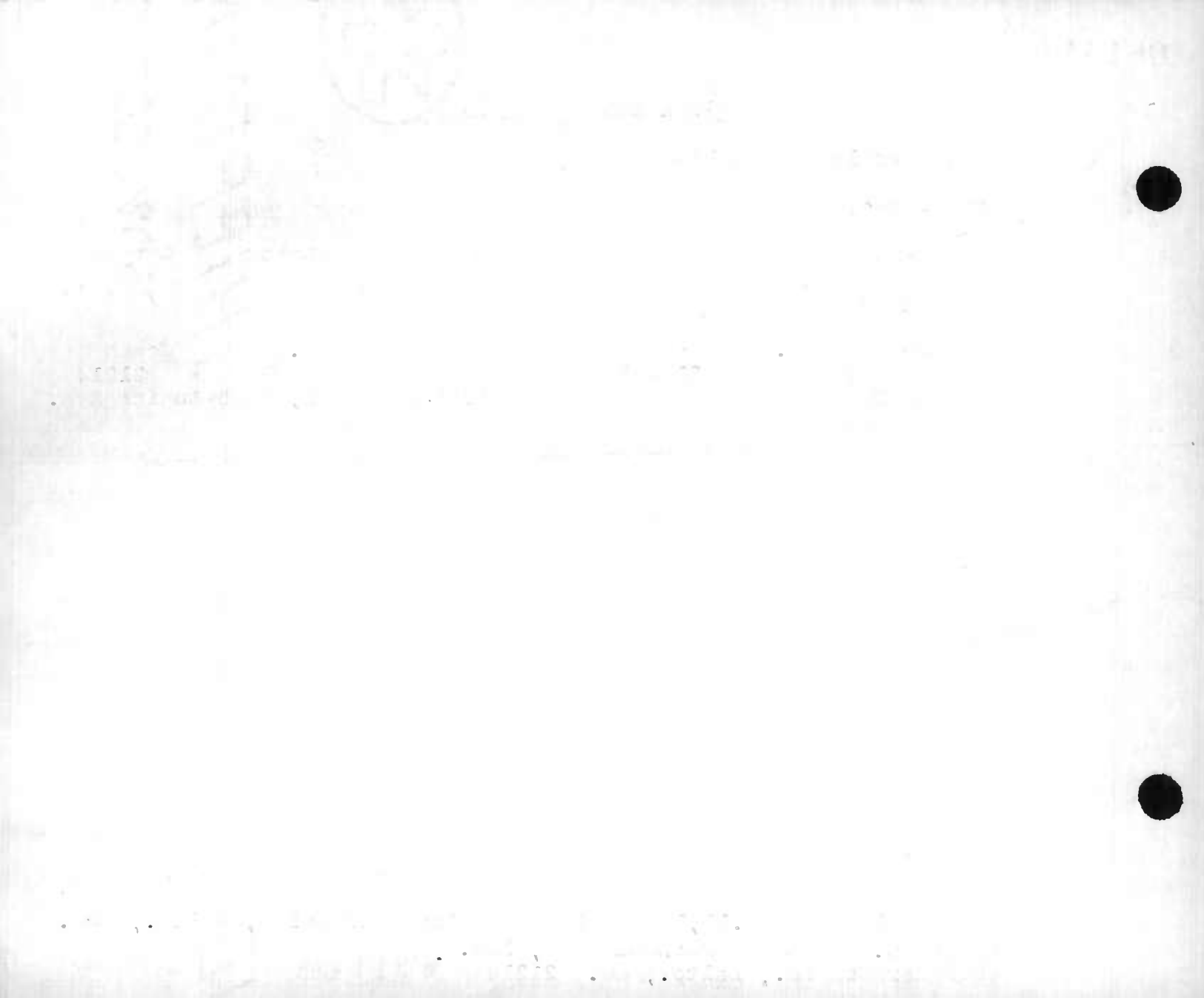
29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 4 and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



098014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ☒, show any injury, or other traumatic event, the medical examiner must be called at once.

BP 25

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Hazel H. Mitten</b>			2a DATE OF DEATH MONTH DAY YEAR <b>March 30, 1985</b>		2b HOUR <b>10:30 PM</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>OCT. 24, 1901</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
13a STATE <b>Maryland</b>	13b COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Towson</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>625 Sussex Rd. 21204</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Hughes</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice R. Parks</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>214-01-6032</b>	17 INFORMANT ADDRESS <b>Wm. B. Stansbury, Jr. 508 Club Rd. Towson, Md. 21204</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF <b>Complications of Abdominal</b> (b) <b>Carcinomanosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Unknown</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a DATE OF OPERATION <b>March 29, 1985</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Colonic Obstruction</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 29, 1985</b> to <b>March 30, 1985</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 30, 1985</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.					
22b SIGNATURE <i>[Signature]</i>		DEGREE <b>MD</b>		22c DATE SIGNED <b>3/31/85</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEWIS M SCHMIDT</b>		22e ADDRESS <b>c/o Maryland General Hospital</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>4/2/85</b>	23c NAME OF CEMETERY OR CREMATION <b>Loudon Park</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>
24 FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc.</b>		ADDRESS <b>6500 York Rd. Balto., Md. 21212</b>		25a DATE REC'D. BY REGISTRAR <b>APR 2 - 1985</b>	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

07891

FOR  
STATE  
REGISTRAR

081344

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR			
NAOMI COLEMAN		MOBLEY						3-3-85		19		M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR			
Female	Black	1 14 10		75 YRS.				3-3-85		19		6:25A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
VA		USA				Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		1836 Collington (N)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MD				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1833 N. Collington Ave.				21213			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Andrew Coleman				Maude Wilson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No				214-22-2068				Rev. Abraham Coleman				4118 Kathland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Margarita A. Korell</u>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 3-3-85			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Margarita A. Korell, M.D.				111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial		3/7/85		Arbutus Mem. Pk.		Baltimore		Co.		MD					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. C. March F/H				1101 E. North Ave.				MAR 5 1985		<u>La Davidson-Randall</u>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Deacon WILLIAM H. MULLOCK			2a. DATE OF DEATH MONTH DAY YEAR 3-14-85			2b. HOUR 8:10 P.M.	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 11-23-05		6. AGE (IN YEARS LAST BIRTHDAY) 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1929 W. Fayette St. 21223	
14. FATHER'S NAME FIRST MIDDLE LAST - - -				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST - - -							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 716-01-7557		17. INFORMANT ADDRESS Walter Hurt, Jr. 1929 W. Fayette St.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____			
DUE TO, OR AS A CONSEQUENCE OF (c) _____			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/14</u> , 19 <u>85</u> , to <u>3/14</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/14</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>L. C. CUEVO</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEDRUING L. CUEVO				22e. ADDRESS LUTHERAN HOSPITAL			

23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 3/19/85		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem. Baltimore,		23d. LOCATION COUNTY STATE Md.	
24. FUNERAL DIRECTOR Wm C March F/H Inc. 1101 E North Avenue				25a. DATE OF DEATH BY REGISTER		25b. REGISTRAR'S SIGNATURE Wm C March	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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THE UNIVERSITY OF CHICAGO  
LIBRARY

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20% COTTON



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SARAH MONGER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-9-85</b>		2b. HOUR M
3. SEX <b>Female</b>	4. RACE <b>Col</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 13 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SUMTER S.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4018 BARRINGTON Rd</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK MONGER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		13. STREET ADDRESS / ZIP CODE <b>4018 BARRINGTON Rd. 21207</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-74-2220</b>		17. INFORMANT ADDRESS <b>ADA MARSHALL 4018 BARRINGTON RD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 MO.</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension.</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Organic Brain Syndrome</b>					
19a. DAY OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <b>August 30</b> , 19 <b>84</b> , to <b>March 9</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>March 5</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (dual) (did not) view the body after death.					
22b. SIGNATURE <b>George Teler, M.D.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>Mar. 11, 1985</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George Teler, M.D.</b>		22e. ADDRESS <b>680 Light St. Bell. Md. 21230</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>3-16-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT ZION CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LANDOWNE Md</b>	
24. FUNERAL DIRECTOR NAME <b>J. L. Russ</b>		ADDRESS <b>2222 W. WORTH AVE</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>	
				25b. REGISTRAR'S SIGNATURE <b>John H. Randle</b>	

MEDICAL CERTIFICATION

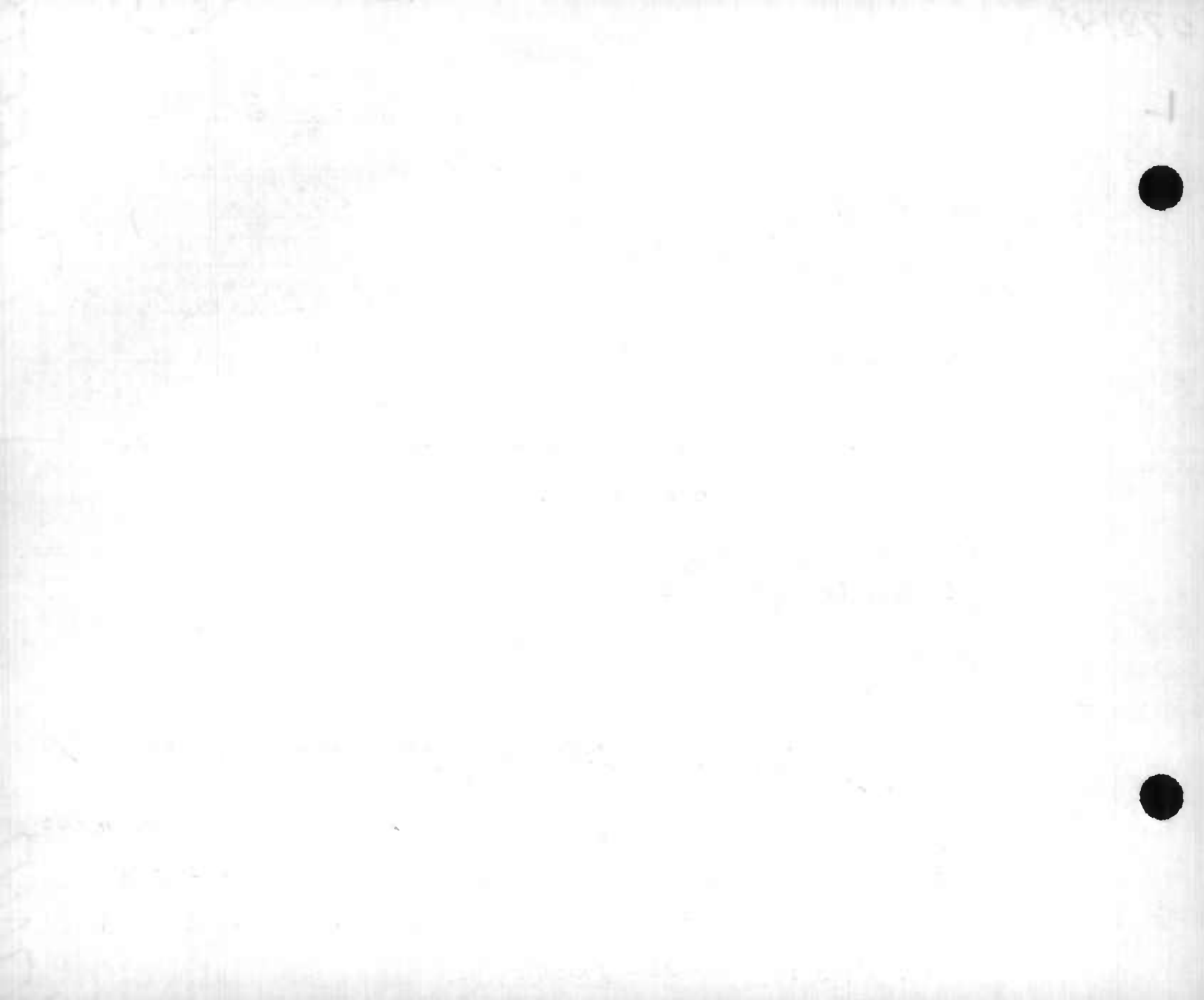
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 50M 1/81  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ARTHUR MONROE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 27 85</b>		2b. HOUR <b>M</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 19 06</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>V.A.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lincoln Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABOR</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION):					
13a. STATE <b>Md.</b>	13b. COUNTY	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1217 W. Fayette St. 21223</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ARTHUR MONROE SR</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA PAYNE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-03-5548</b>	17. INFORMANT ADDRESS <b>DELORES LEON 109 SUMMER AVE BLK 4A NY 11206</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Collapse</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia, reserpt.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 3-25-85</b> to <b>Dec 27-85</b> , that (I) (we) last saw the deceased alive on <b>Dec 25-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) saw the body after death.					
22b. SIGNATURE <b>A.I. Baykaler, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3-29-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A.I. BAYKALER, M.D.</b>		22e. ADDRESS <b>831 Poplar Grove St. Bal. 21216</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/30/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT ZION</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>
24. FUNERAL DIRECTOR NAME <b>BETTS F/H</b>		ADDRESS <b>1129 N. CAROLINE</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 1 - 1985</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

011100

011100



RECEIVED

ON 11/11/50 10:15 PM BY JAMES  
1000 1000 1000 1000 1000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

092074

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST ERNEST G MONTGOMERY JR.			MONTH / DAY / YEAR 03 / 26 / 85			4:25 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
M	W	MONTH / DAY / YEAR 3 / 2 / 54	31 YRS.			MONTHS / DAYS / HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
MD.	USA		BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	THE JOHNS HOPKINS HOSPITAL					COUNTY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD. BALTO ESSEX			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			126 ALCOCK RD 21221		
FATHER'S NAME FIRST MIDDLE LAST ERNEST MONTGOMERY SR			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SHIREY WADDELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
UNK			21366 5846			CHERYL MONTGOMERY ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Corbion Aneur</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mins</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral aneurysm, ALC colitis</u>								<u>2 years</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Squamous lung CA, all transmigration</u>								<u>2 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/11/85</u> to <u>3/26/85</u> that (I) (we) lost saw the deceased alive on <u>3/26/85</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE <u>Armedo Acevedo</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/26/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Armedo Acevedo</u>						22e. ADDRESS <u>Johns Hopkins Hospital</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>3/28/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DAK LAWN</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTO MD</u>	
24. FUNERAL DIRECTOR NAME <u>J.G. CONNELLY</u>						25a. DATE REC'D. BY REGISTRAR <u>MAR 28 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Haroldson-Randall</u>
ADDRESS <u>300 MACE</u>								

MEDICAL CERTIFICATION

7842

EX-100

4

RECEIVED  
FEB 10 1964  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

*[Faint, mostly illegible text, possibly a letter or report, with some visible words like "Dear Sir", "enclosed", and "very truly yours"]*



078144

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 0 7 8 9 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HOUSTON C. MOODY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03-15-85</b>		2b. HOUR <b>5:15 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2-08-11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GEN.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>649 CHERATON RD 21225</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA A Garrett</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-07-4453</b>		17. INFORMANT ADDRESS <b>Ida Mae Moody 649 Cheraton Road</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest 2° severe</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>hypoglycemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diffuse metastatic adenoCa of prostate</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Poss. 2nd Primary Bronchogenic Ca</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> 19 <b>85</b> , to <b>3/15</b> 19 <b>85</b> , that (I) <input checked="" type="radio"/> saw the deceased alive on <b>3/15/85</b> and that in (my) <input checked="" type="radio"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="radio"/> (we) <input type="radio"/> did not view the body after death.					
22b. SIGNATURE <b>W. Rahming</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/15/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. RAHMING</b>		22e. ADDRESS <b>3001 S. Hanover St.</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3/21/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Anne Arundel Co., Md.</b>
24. FUNERAL DIRECTOR <b>Wm C March F/H Inc. 1104 E North Ave.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>	25b. REGISTRAR'S SIGNATURE <b>Johia Davidson-Randall</b>	

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07897

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Frances Mooney</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 9 85</b>		2b. HOUR <b>9<sup>25</sup> P.M.</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 29, 1893</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Jenkins Memorial Home</b> <b>1000 S. Caton Ave. 21229</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>seamstress</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>garment</b>		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13b. STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Baltimore</b>		13e. STREET ADDRESS <b>1000 S. Caton Ave 21229</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Norris</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Brothers</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-10-9059</b>		17. INFORMANT ADDRESS <b>Mary Jordon 1241 Brewster St. 21227</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma colon</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>5/1</b> 19 <b>80</b> to _____ 19 _____, that <del>he</del> (we) last saw the deceased alive on <b>3-9</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above <del>(he)</del> (we) (did) <del>not</del> view the body after death.						
22b. SIGNATURE <b>Laurena R. Gallager, M.D.</b> 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Laurence R. Gallager, M.D.</b>				22c. DATE SIGNED <b>3/11/85</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/13/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery Baltimore City</b>		
24. FUNERAL DIRECTOR NAME <b>Ambrose Funeral Home 1328 Sulphur Spring Road</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Maryland</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>MAR 11 1985</b>		

MEDICAL CERTIFICATION

29

081345

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George Moore			2a. DATE OF DEATH MONTH DAY YEAR March 10, 1985			2b. HOUR M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 7 25		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4022 Forest Park Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Loveless Moore				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-18-6824		17. INFORMANT ADDRESS Bernard Moore 2400 Roslyn Avenue			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Lung Cancer

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1985, to 3, 1985, that (I) (we) last saw the deceased alive on 3/19/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Philip Kent				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

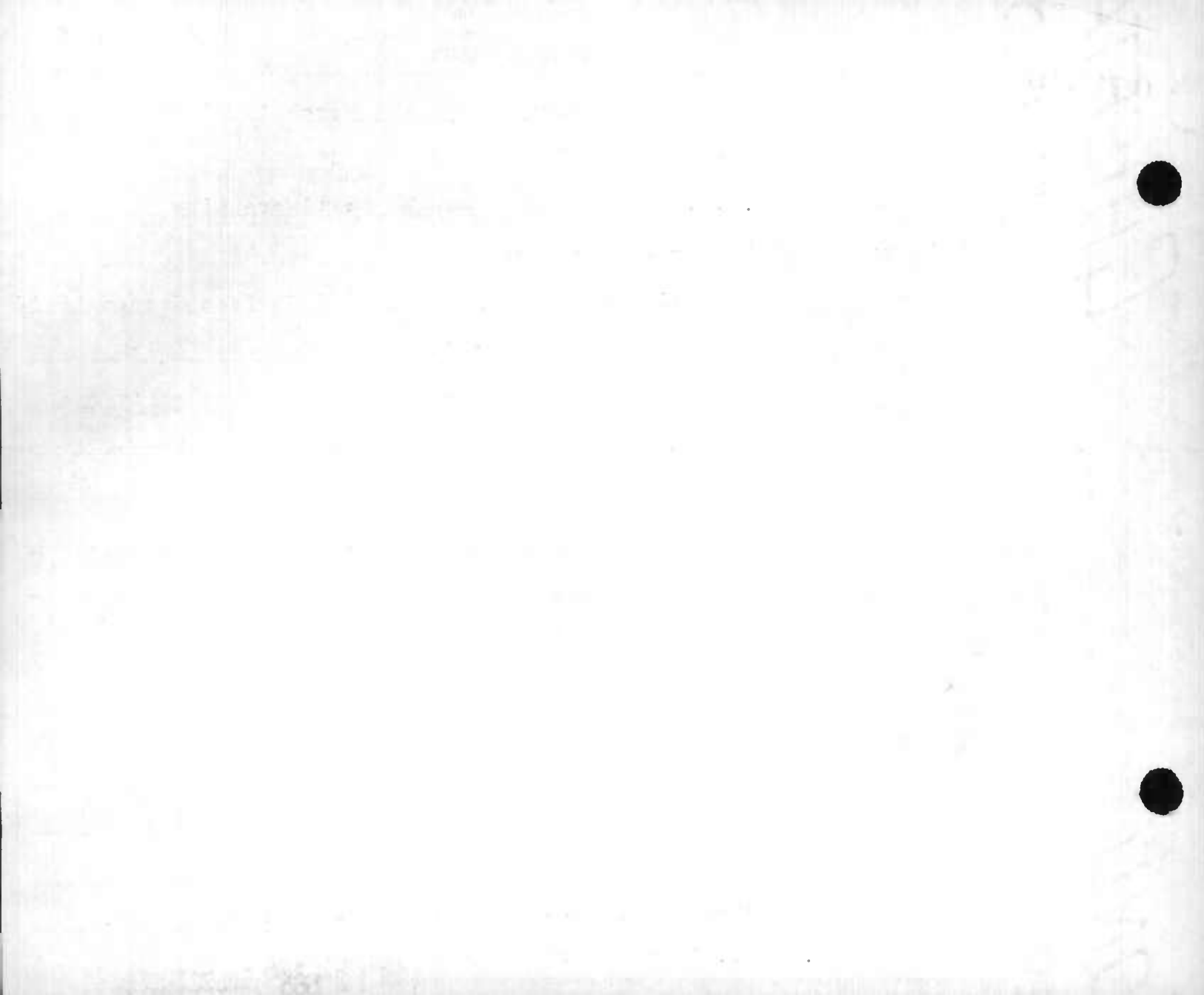
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 3/14/85		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk -Arbutus,		23d. LOCATION CITY OR TOWN COUNTY STATE Md.	
24. FUNERAL DIRECTOR NAME Wm March F.H Inc. 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR MAR 12 1985		25b. REGISTRAR'S SIGNATURE Jana Jordan-Henderson	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







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W. J. COX & CO. LTD.

W. J. COX & CO. LTD.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 9 0 0

087082

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>James B. Moore</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03-20-85</b>		2b. HOUR <b>1149</b> M
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 1, 1952</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>33</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ACCOUNTANT</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>A.A. CO.</b>	13c. CITY OR TOWN <b>21061</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>HERBERT B. MOORE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH C. CAMPION</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-----</b>	17. INFORMANT ADDRESS <b>DEBORAH R. MOORE 8135 HAROLD CT. 21061</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>COMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebrovascular Accident and Metabolic Cause.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Pneumonia; Diabetic Ketoacidosis; Chronic Renal failure on Dialysis Treatment</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/7/85</b> , to <b>3/20/85</b> , that (I) (we) lost saw the deceased alive on <b>3/20</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE <b>HARI K BHASIN</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>3/20/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HARI K BHASIN MD</b>		22e. ADDRESS <b>606 HAMMONDS LANE BALTO MD 21225</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>	23b. DATE <b>MAR. 23, '85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CEMETERY</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>WILLIAM E. JOHNSON</b>		ADDRESS <b>8521 LOCH RAVEN BLVD.</b>	25a. DATE REC'D. BY REGISTRAR <b>MAR 22 1985</b>	25b. REGISTRAR'S SIGNATURE <b>William E. Johnson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 9 0 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGURITE E. MOORE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 3, 1985</b>		2b. HOUR <b>11:02<sup>AM</sup></b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 26, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>56</b>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Michigan</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Burns</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Morgan</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>367-28-5849</b>	
17. INFORMANT ADDRESS <b>Edwin D. Moore Same as # 13</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-27</b> , 19 <b>85</b> , to <b>3-3</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3-3</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)							
22b. SIGNATURE <b>Joseph S. Weinstein</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-3-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph S. Weinstein</b>				22e. ADDRESS <b>Baltimore, Md. Johns Hopkins Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/6/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	
5555 Twin Knolls Road, Columbia, Md. 21045							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove complete Pages 3 and 4 and retain them for 72 hours after burial. If the deceased was not buried within 72 hours after death, the funeral director should be notified. IMPORTANT: If item 21 is marked or item 18 shows any injury, the death certificate is a report of a traumatic event, the death certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 9 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John Morgan</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 22, 1985</b>		2b. HOUR <b>4:38 PM</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2-19-1920</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Morgan</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Morgan</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII 224-26-6844</b>		17. INFORMANT ADDRESS <b>Adell Gladden 4511 Wakefield Rd.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) **Pulmonary Embolism**

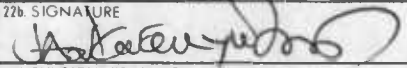
DUE TO, OR AS A CONSEQUENCE OF

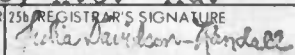
(b) **Atherosclerotic Cardiovascular Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>March 10, 1985</b> , to <b>March 22, 1985</b> , that (we) lost saw the deceased <b>March 22, 1985</b> , and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above, (X we) (did) (not) see the body after death.			
22b. SIGNATURE 	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>3/23/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH A. NKWANYUO</b>		22e. ADDRESS <b>c/o Maryland General Hospital</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3-27-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, H.C. Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Charles A. Rice FSPA 1300 Eutaw Pl.,</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 29 1985</b>	
		25b. REGISTRAR'S SIGNATURE 	

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March 22, 1963



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 9 0 3

FOR  
1. STATE  
REGISTRAR

REG. NO.

444  
092035

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Aubrey E. Morris Sr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 22 85</i>		2b. HOUR <i>1:10 AM</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 25 20</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA. H/A</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Baltimore Gen. Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>retired</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Beth Steel</i>	
13a. STATE <i>Md</i>			13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Elijah ----- Morris</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>GAORAK E. Knight</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>W. W. 2 229-14-7706</i>		17. INFORMANT ADDRESS <i>Mrs. Hazel P. Morris, Same as above</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinomatous</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Carcinoma of Pancreas</i> DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>March 5</i> 19 <i>85</i> , to <i>March 22</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>March 22</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Jorge J. Acevedo Vela</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>3/22/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jorge J. Acevedo Vela</i>		22e. ADDRESS <i>3001 S Hanover St. Baltimore, Md</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>Mar. 26, 1985</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Crownsville, V.A. Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Crownsville, Maryland</i>
24. FUNERAL DIRECTOR NAME <i>McCutty Funeral Home. 130 E. Fort Ave. Balto. Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 27 1985</i>	25b. REGISTRAR'S SIGNATURE <i>James W. ...</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



0800222

MR. PURVIS  
RELEASED AS NON-MED DR. KAUFFMANN PER  
TO HOSPITAL OR ATTENDING PHYSICIAN; the law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. The deceased must be taken to the funeral home prior to burial, cremation or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

0 7 9 0 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (LAST OR PRINT) FIRST MIDDLE LAST <b>HURBERT (HERBERT) L. MORROW</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 17, 1985</b>		2b. HOUR A <b>1:26 M</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-9-1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>73</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CHAFFEUR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TRUCKING</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>529 N. BELNORD AVE. 21205</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HUGH MORROW</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LAURA RIEGLE</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				
16b. SOCIAL SECURITY NO. <b>214-14-5744A</b>			17. INFORMANT ADDRESS <b>Mrs. Julia E. Morrow - 529 N. Belnord Ave. 21205</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>chronic obstructive pulmonary disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b></b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3/17 1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <b>3/17</b> 19 <b>85</b> , to <b>3/17</b> 19 <b>85</b> , that (I) (we) lost above <b>(b)</b> (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>M. G. Threlkeld</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/17/85</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. G. Threlkeld</b>		
22e. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST. BALTO. MD. 21205</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MARCH 20, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>		
24. FUNERAL DIRECTOR NAME <b>HARTLEY Miller FUNERAL HOME</b>		ADDRESS <b>2334 JEFFERSON ST.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>		BP		

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ANTONIA J. MOURDY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 18, 1985</b>			2b. HOUR <b>4A.</b> M.			
3. SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>JAN. 2, 1897</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6411 MARISTTA AVE.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AT HOME</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>MARYLAND</b>				13b COUNTY		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH PETER</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARIE POSSIPIL</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>NO</b>				16b SOCIAL SECURITY NO. <b>212 0571380</b>		17 INFORMANT ADDRESS <b>FAMILY RECORDS</b>			

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Acute CVA**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHConditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

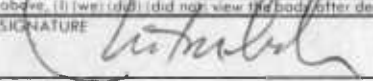
(b) **ASCVD**

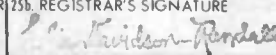
DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) this hospital attended the deceased from <b>3/16</b> , 19 <b>85</b> to <b>3/17</b> , 19 <b>85</b> , that (ii) (we) last saw the deceased alive on <b>3/16</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (i) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>MARCH 19, 1985</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. NESTOR M. CARMONA</b>				22e. ADDRESS <b>6012 HARFORD ROAD</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3-21-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>EVANS CHAPLOF MEMORIAL HARFORD RD. 8800</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1985</b>		25b. REGISTRAR'S SIGNATURE 	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



## MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



[illegible]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 07907

REG. NO.

1- STATE REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Samuel A Moulton Sr</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03/06/85</b>		2b. HOUR <b>11:15 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>08 09 30</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City MD.</b>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIV. OF MARYLAND HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. NAME OF BUSINESS OR INDUSTRY <b>Public Schools</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH JONES</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CLARA MOULTON</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>216-24-9893</b>		17. INFORMANT <b>Jessie E. Moulton</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>probable pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Prostatic Carcinoma Metastatic</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>days</b> <b>1982</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Trousseau's Syndrome, GI bleeding and thrombocytopenia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I (this hospital) attended the deceased from <b>February 13, 1985</b> , to <b>March 6, 1985</b> , that (we) last saw the deceased alive on <b>March 6, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John A. Ulatowski MD</b>		DEGREE		22c. DATE SIGNED <b>3-7-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John A. Ulatowski MD</b>		22e. ADDRESS <b>22 S. Greene St. Balt. Md 21203</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/11/1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Nutter &amp; Sons 2501 Gwynns Falls Parkway</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Gula Davidson-Randall</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Colonel A. Moulton Jr

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Received



City  
St. Louis, Mo.  
Public Schools

No. 216-4-1213 Jan 21. 1918  
6008 Corcoran Avenue  
St. Louis, Mo.

General Home, Inc., Baltimore, Maryland  
Butter & Jones, 2001 B Street, Baltimore  
Baltimore, Maryland

0860871

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thelma E. Mullins			2a. DATE OF DEATH MONTH DAY YEAR March 19, 1985		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 06 1912	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1609 Elrino St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1609 Elrino St. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Unk			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-03-3938	17. INFORMANT ADDRESS Bernadette Sachs 5 Ivy Bridge Ct. 21136		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ischemic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minute</u> <u>year</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>inflammation</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from <u>3/14</u> , 19 <u>85</u> , to <u>3/20</u> , 19 <u>85</u> , that (I/we) lost saw the deceased alive on <u>3/14</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John R. Burton, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/20/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Burton, M.D.		22e. ADDRESS 5200 Eastern Ave.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 03/21/85	23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Connelly Funeral Home Of Dundalk		25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DOROTHY Munday			2a. DATE OF DEATH MONTH DAY YEAR 03 17 85			2b. HOUR 5.45 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 3 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH city		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lincoln Conv. Ctr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (patient)	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-40-6504		17. INFORMANT ADDRESS	

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) TERMINAL Cancer primary unknown

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) mental retard

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>3/17</u> 19 <u>85</u> , to <u>3/17</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/17</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kuanyen Huang M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/17/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANYEN HUANG				22e. ADDRESS Lincoln Nursing Home			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/25/85		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR Betts Funeral Home-1129 N. Caroline				25a. DATE REC'D. BY REGISTRAR MAR 21 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



087062

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 9 1 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOA E. MURPHY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-19-85</b>			2b. HOUR <b>8 40 A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 12 30</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Canada</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. City</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTO. City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bow Secord Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK - MOST OF WORKING LIFE) <b>L.P.N.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William J. Marshall</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca Fowler</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>218-07-5623</b>			17. INFORMANT <b>Barbara Murphy</b>			ADDRESS <b>Same as 13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Vascular Collapse</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3-1-85</b> , 19 <b>85</b> , to <b>3-19-85</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3-19-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A. I. Baykaler, M.D.</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>3-19-85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. BAYKALER, M.D.</b>					22e. ADDRESS <b>831 Poplar Grove St. Bal.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/22/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>George J. Gonce 4001 Ritchie Hwy Balto Md</b>					25a. DATE REG. BY DEPT. OF HEALTH <b>MAR 22 1985</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove card 10 (page 1) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above, any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 85 07911			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 3 16 85			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JERRY LEE MURPHY				2b. HOUR 2:46a M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-28-1949		6 AGE (IN YEARS LAST BIRTHDAY) 36 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven Veterans Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Asa Lee		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Belle Arrowood		13e. STREET ADDRESS / ZIP CODE Hudson Rd. Rt 1 Box 26A 21613			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Vietnam 217-50-2739		17 INFORMANT ADDRESS Betty Murphy, Same as 13e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) cardiopulmonary arrest							
DUE TO, OR AS A CONSEQUENCE OF (b) peritonitis alcoholic cirrhosis							
DUE TO, OR AS A CONSEQUENCE OF (c) renal failure							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that X (this hospital) attended the deceased from MARCH 9 19 85, to MARCH 16 19 85, that X (we) last saw the deceased alive on MARCH 16 19 85, and that in X (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KMETZO				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-19-85		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Memory		23d. LOCATION CITY OR TOWN COUNTY STATE Hebron, Md/	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., Balto., Md. ADDRESS				25a. DATE REC'D. BY REGISTRAR MAR 18 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

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FBI - NEW YORK

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 7 9 1 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian C. Murphy			2a. DATE OF DEATH MONTH DAY YEAR March 13, 1985		2b. HOUR M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 28 98	6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5410 Addington Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Ahome	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALT. 13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5410 Addington Rd. 21229	
14. FATHER'S NAME FIRST MIDDLE LAST Willie Coleman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patty Richardson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-01-6292	17. INFORMANT ADDRESS Gloria Hendrick 5410 Addington Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ISCHAEMIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) / Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: /					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 2/8, 1985, to 3/13, 1985, that (I) (we) lost saw the deceased alive on 3/13, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A.K. Chopra, M.D.			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/13/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.K. Chopra, M.D.			22e. ADDRESS 3455 Wilkens Ave. Baltimore, Md. 21229		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/16/85	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE Landover P.G.		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.			25. DATE RECEIVED BY REGISTRAR MAR 27 1985		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 9 1 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARTHA Frances MURPHY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 23, 1985</b>			2b. HOUR <b>12:20am</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 15 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
12. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Chemical</b>		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>Maryland</b>			16b. CITY <b>Harford</b>		16c. CITY OR TOWN <b>Joppa</b>		17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS / ZIP CODE <b>4 Neptune Court 21085</b>	
19. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Frank Fairbrother</b>			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Frances Leffler</b>							
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		22. SOCIAL SECURITY NO. <b>137-32-8859</b>		23. INFORMANT <b>Barbara A. Just</b> ADDRESS <b>6632 Walnutwood Circle Baltimore, Md. 21212</b>						
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPOXEMIA</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>HEMOTHORAX</b>								<b>4 days</b>		
(c) <b>ATAXIC FALL</b>								<b>6 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>BRONCHITIS CARCINOMA</b>										
25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED				27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
32. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE						
35. I certify that (I) <u>this hospital</u> attended the deceased from <u>3/18</u> , 19 <u>85</u> , to <u>3/23</u> , 19 <u>85</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>3/23</u> , 19 <u>85</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.										
36. SIGNATURE <i>C. W. Hendrix</i>				37. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				38. DATE SIGNED <b>3/23/85</b>		
39. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. W. HENDRIX</b>				40. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL 600 N. WOLFE STREET, BALTIMORE, MD</b>						
41. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		42. DATE <b>Mar. 27, 1985</b>		43. NAME OF CEMETERY OR CREMATORY <b>Cem. Immaculate Conception</b>		44. LOCATION CITY OR TOWN COUNTY STATE <b>Montclair Essex New Jersey</b>				
45. FUNERAL DIRECTOR NAME ADDRESS <b>HOWARD K. MCCOMAS III Abingdon, Maryland 21009</b>				46. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>		47. REGISTRAR'S SIGNATURE <i>John Davidson</i>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, it may be any injury, or other traumatic event, or medication, or other cause of death.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 9 1 4

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>NELLIE MURPHY</b>		2a DATE OF DEATH MONTH DAY YEAR <b>3-2-85</b>		2b HOUR <b>8:40 A</b> M	
3. SEX <b>F</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 22 92</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN HOSPITAL</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> , MD.	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-30-6075A</b>		17 INFORMANT ADDRESS <b>Apt. 805 Beatrice McGuire 1100 Pennsylvania Ave</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebrovascular Accident</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Congestive heart failure - Pneumothorax</b>					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-16</b> , 19 <b>85</b> , to <b>3-1</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3-1</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Bich T Duong</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3/2/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BICH T DUONG</b>		22e ADDRESS <b>LUTHERAN HOSPITAL</b>			
23a BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3/6/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Pk.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Md.</b>					
24 FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H Inc. 1101 E North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Davidson-Randall</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

081349



081110



REPORT OF THE  
COMMISSIONER OF THE  
GENERAL LAND OFFICE  
TO THE SECRETARY OF THE  
INTERIOR

U.S. GOVERNMENT  
PRINTING OFFICE  
WASHINGTON, D.C.





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE Mitchell		LAST MURRAY		2a. DATE OF DEATH		MONTH YEAR		2b. HOUR	
EVELYN						March 25, 1985				11:03p	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Black		MONTH DAY YEAR 4 19 32		52 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
Maryland		U.S.A.									
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Maryland				Baltimore				13e. STREET ADDRESS / ZIP CODE 2710 East Chase St. 21213			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST John Mitchell		FIRST MIDDLE LAST Etta Myers									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Christopher Mitchell 2710 E. Chase St							
NO		213-30-3128									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypotension</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Bradycardia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>10 min</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>metastatic Breast cancer with liver failure</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) (this hospital) attended the deceased from <u>3/22</u> , 19 <u>85</u> , to <u>3/25</u> , 19 <u>85</u> , that (i) (we) last saw the deceased alive on <u>3/25</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (ii) (we) (did) (did not) view the body after death. <u>11:03 pm</u>											
22b. SIGNATURE <u>Edward Kasper</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>3/25/85</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EDWARD KASPER</u>		22e. ADDRESS <u>Johns Hopkins Hospital</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>4/1/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Md. Veteran Cem.</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Crownsville, Md.</u>			
24. FUNERAL DIRECTOR Wm C March F/H Inc. 1101 <sup>ADDRESS</sup> E North Avenue						25a. DATE REC'D. BY REGISTRAR <u>MAR 27 1985</u>		25b. REGISTRAR'S SIGNATURE <u>F. A. Swickard-Randall</u>			

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY CATHERINE NEEB			2a. DATE OF DEATH MONTH DAY YEAR 03 19 85		2b. HOUR 2:45 P M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 01 18 1894		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHERRY PITTEER		12b. KIND OF BUSINESS OR INDUSTRY CONFECTIONERY		13a. STREET ADDRESS / ZIP CODE 1933 HARMAN AVENUE, 21230	
14. FATHER'S NAME FIRST MIDDLE LAST WALTER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATE COOPER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 215-05-1876		17. INFORMANT DOROTHY I. BELL		18. ADDRESS 1927 HARMAN AVENUE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia c infected</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Wounds abdomen &amp; elbow</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION 3/15/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Feeding Jejunostomy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/19/85</u> to <u>3/19/85</u> , that (I) (we) last saw the deceased alive on <u>3/19/85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jogendra Singh, M.D.		22c. DATE SIGNED 3/22/84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOGENDRA SINGH, M.D.	
22e. ADDRESS 1190 W. NORTHERN PARKWAY		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 03-23-85	
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND		23e. DATE REC'D. BY REGISTRAR	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 4107 WILKENS AVE.		25. REGISTRAR'S SIGNATURE	

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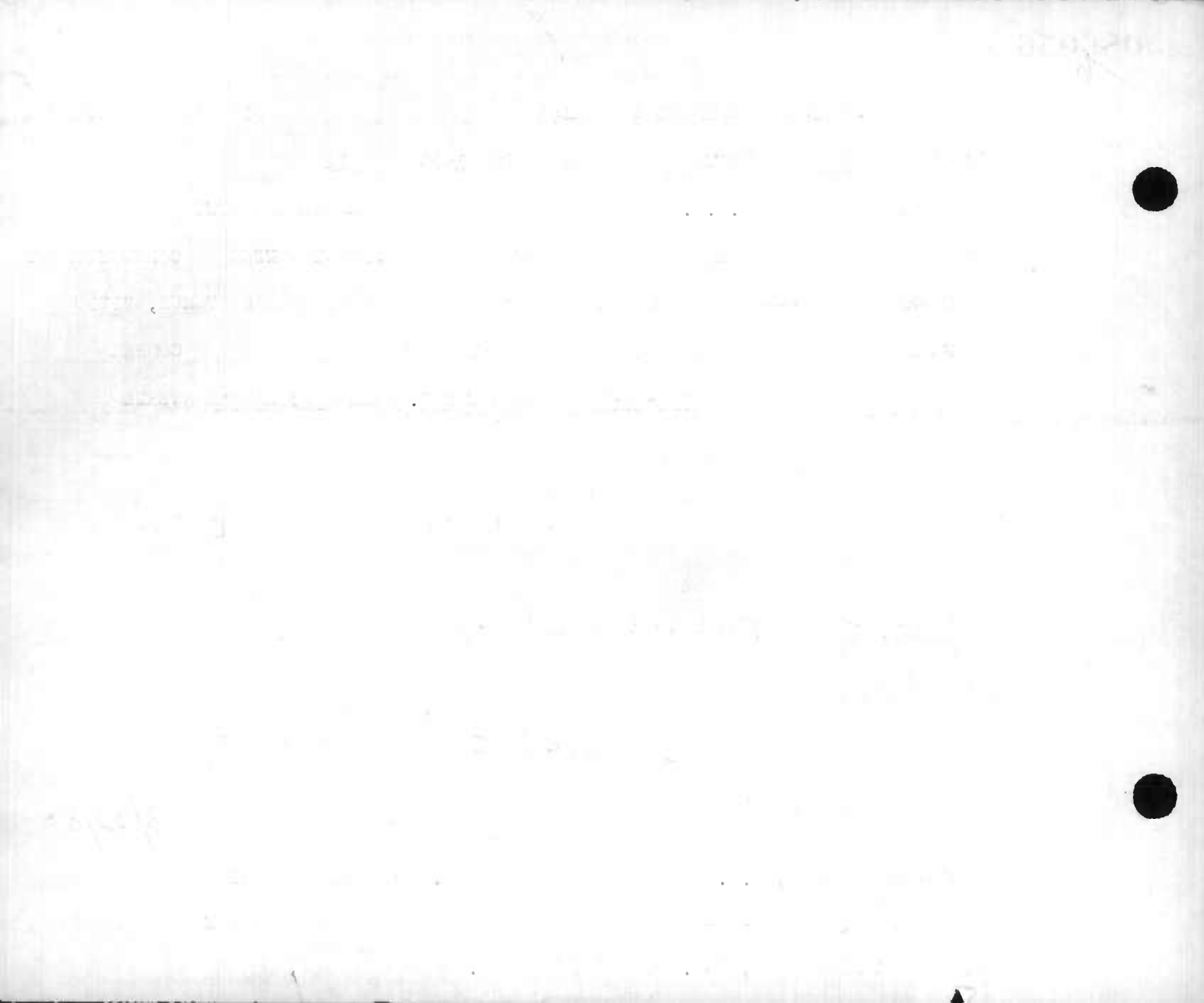
MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



093131

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP\_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				07-917 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Darryl VAUGHN Nelson						2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 3-28 1985		2b. HOUR M A.M.					
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR MAY 9, 1960		6. AGE (IN YEARS) LAST BIRTHDAY 24 YRS.		7c. DATE PRONOUNCED DEAD 3-28 1985		7d. HOUR 8:36 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALT., MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2028 Mt. Royal Terrace				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.						13b. COUNTY N/A		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 256 ROBERT STREET 21217	
14. FATHER'S NAME HORACE						15. MOTHER'S MAIDEN NAME ELTRA CHASE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 213-70-0775		17. INFORMANT ADDRESS ELTRA NELSON 256 ROBERT STREET					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 3-28-85					
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/1/85		23c. NAME OF CEMETERY OR CREMATORY KING MEM. PARK				23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR NAME ADDRESS LEROY O. DYETT 4600 LIB. HGHTS. AV.				25a. DATE REC'D. BY REGISTRAR APR 1 1985		25b. REGISTRAR'S SIGNATURE <i>J. Davidson</i>							

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2/21/85 Item 13 L.J

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT NMI NELSON			2a. DATE OF DEATH MONTH DAY YEAR 03 14 1985			2b. HOUR 5:20 PM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH M. DAY YEAR 11-07-17		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Maryland Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed	
12b. KIND OF BUSINESS OR INDUSTRY							
13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13b. STREET ADDRESS / ZIP CODE Montebello Center 2201			
14. FATHER'S NAME FIRST MIDDLE LAST John Nelson				15. MOTHER'S MAIDEN NAME MIDDLE LAST Ida Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 260-40-0267		17. INFORMANT ADDRESS Robert Nelson 2201 Argonne Dr. Balt MD	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>unknown</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>unknown</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 70 min.
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none

19a. DATE OF OPERATION 2/12/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED small bowel obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> , 19 <u>85</u> , to <u>3/14</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/14</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jack Flowers MD.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Flowers MD				22e. ADDRESS 22 S. Greene St Balt MD 21201			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 03-20-85		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS BROWN/Thompson F.H. 1913 W. BALTA ST.				25a. DATE REC'D. BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE R. R. Rindam-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





098082

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 9 1 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUTH NELSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 31, 1985</b>		2b. HOUR <b>10:30 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 7 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>79</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Home Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Johnson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgia Woolford</b>			13e. STREET ADDRESS / ZIP CODE <b>1808 N. Washington St. #13</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-14-3543A</b>		17. INFORMANT ADDRESS <b>Naomi J. Doles 1808 N Washington St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>DIABETES MELLITES</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>CHURCH HOSPITAL</b> <b>100 NORTH BROADWAY 21231</b>				
22a. I certify that (I (the hospital) attended the deceased from <b>MARCH 30</b> , 19 <b>95</b> , to <b>MARCH 31</b> , 19 <b>85</b> , that (I (we) last saw the deceased alive on <b>MARCH 31</b> , 19 <b>85</b> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did) (did not) view the body after death.								
22b. SIGNATURE <i>Paul Gormley</i>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/31/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL GORMLEY</b>				22e. ADDRESS <b>CHURCH HOSPITAL</b> <b>100 NORTH BROADWAY 21231</b>				
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>4/5/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Wm C March F/H Inc, 1101 E North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 2 - 1985</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) James A Neubert			2a. DATE OF DEATH MONTH DAY YEAR 3 13 85		2b. HOUR 9:30 PM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10 16 1911		6. AGE (IN YEARS, LAST BIRTHDAY) 73 YRS MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY produce	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Andrew		15. MOTHER'S MAIDEN NAME Emma Hamilton		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-01-7982	
				17. INFORMANT Mrs. Marie Neubert-3705 Hudson St.		ADDRESS 21224	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic heart disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Congestive heart failure

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (the deceased) attended the deceased from February 13, 1985 to March 13, 1985, that (I) (we) last saw the deceased alive on March 13, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>L. K. Peredo</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/13/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. K. Peredo, M.D.		22e. ADDRESS Church Hospital 100 N. Broadway 21231					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-16-85		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley 21224		23d. LOCATION CITY OR TOWN COUNTY STATE Towson, Maryland	
24. FUNERAL DIRECTOR Zannino Funeral Home, 263 S. Conkling				25a. DATE REC'D. BY REGISTRAR MAR 15 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	YEAR	2b. HOUR		
ESTELLE K. NEWHOUSE					MARCH 21, 1985				10:30 P		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		JAN. 18, 1922		63 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
GEORGIA		USA									
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
MARYLAND		BALTO.		BALTIMORE				6309 GREEN MEADOW PKWY. #21209			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
MICHAEL KRICH				FANNIE SHOCKET							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT MR. ELMER M. NEWHOUSE ADDRESS 6309 GREEN MEADOW PKWY. BALTO., MD 21209							
NO		214-14-5963									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Ventricular Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Primary Pulmonary Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>S/P Mitral Valve Replacement</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>long standing</u> <u>7 hrs</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION <u>3/21/85</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Mitral Replacement</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3/20</u> , 19 <u>85</u> , to <u>3/21</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/21</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Wm C Dooley MD</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>								22c. DATE SIGNED <u>3/21/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wm C Dooley MD</u>				22e. ADDRESS <u>Johns Hopkins Hospital</u> 21205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 24, 1985		23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH-BETH ISRAEL		23d. LOCATION CITY OR TOWN COUNTY STATE					
						BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR MAR 27 1985		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <i>Amanda Elizabeth Neuman</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>March 4, 1985</i>		2b. HOUR <i>7A.</i>	
1. SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>3 30 '97</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>87</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		
10 CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF 10 IS NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) <i>3029 East Baltimore Street</i>			12a. USUAL OCCUPATION (TYPE OR WORK OR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>
13a. STATE <i>Maryland</i>	13b. COUNTY <i>-----</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>3029 East Baltimore St. 21224</i>		
14 FATHER'S NAME FIRST MIDDLE LAST <i>Charles Hines</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Carrol</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS <i>Garnette Deegan 626 S. Umbra St. 21224</i>		
16a. <i>No</i>		16b. <i>220-14-0392</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Arterio Sclerosis and Hypertension</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (the hospital) attended the deceased from <i>June 16, 1983</i> to <i>March 4, 1985</i> , that (1) (he) lost saw the deceased alive on <i>Feb 14, 1985</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (person) did not view the body after death.						
22b. SIGNATURE <i>A. C. Alvarez, MD</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/9/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. C. ALVAREZ, MD</i>		22e. ADDRESS <i>302 St. Paul Place Balto, Md</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>3-7-85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart of Jesus</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Dundalk, Balto. Co. Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Charles S. Zeiler &amp; Son Inc.</i>		ADDRESS <i>6224 Eastern Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 5 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	5	0	7	9	2	3
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>George John Newberger</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>March 15, 1985</b>				2b. HOUR <b>6:15 A</b>		
3. SEX <b>Male</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>March 8, 1906</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b>							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3411 E. Lombard Street</b>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>City of Balto-Sanitation</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>21224</b>			
13a. STATE <b>Md.</b>			13b. COUNTY			13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>3411 E. Lombard St.</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Newberger</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Spring</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>						16b. SOCIAL SECURITY NO. <b>220-05-1178</b>		17. INFORMANT ADDRESS <b>A Mrs. M. Newberger, 3411 E. Lombard</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ante RSP FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF <b>COF</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>ATRIAL FIBILLATION</b> (c) <b>ATRIAL FIBILLATION</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>																
19a. DATE OF OPERATION <b>NA</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>NA</b>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>NA</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>June 1983</b> to <b>Feb 1985</b> , that (I) (we) lost saw the deceased alive on <b>Feb 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>[Signature]</b>						DEGREE <b>MD</b>				22c. DATE SIGNED <b>2-17-85</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. H. PRASAD AR. M.D.</b>						22e. ADDRESS <b>3413 E Lombard St BTR</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>3-18-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Jesus</b>				23d. LOCATION CITY OR TOWN COUNTY <b>Baltimore, Maryland</b>						
24. FUNERAL DIRECTOR <b>Joseph N. Zannino, 263 S. Conkling St.</b>										25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

MEDICAL CERTIFICATION

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George John Newberry March 12, 1902

Mr. J. H. ... March 12, 1902

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 07924

088059 OR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HOWARD G. NEWTON</b>			7a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 24 1985</b>		7b. HOUR <b>11:40 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 27 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3015 Mondawmin Ave. 21216</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Newton</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene Rhodes</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-16-2205</b>		17. INFORMANT ADDRESS <b>Malinda M. Newton 3015 Mondawmin Ave.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIOPULMONARY ARREST**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**one hour**

DUE TO, OR AS A CONSEQUENCE OF

(b) **METABOLIC ACIDOSIS****5 days**

DUE TO, OR AS A CONSEQUENCE OF

(c) **RENAL FAILURE****2 1/2 weeks**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d)

**Congestive Heart Failure**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <b>3/14</b> 19 <b>85</b> , to <b>3/24</b> 19 <b>85</b> , that (b) (we) last saw the deceased alive on <b>3/24</b> 19 <b>85</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stephen M. Seabron</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/25/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN M. SEABRON</b>		22e. ADDRESS <b>2600 Liberty Bkts. Ave. BALTO 21215</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/29/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b>
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>	25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>
		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 07925

0947121- FOR  
STATE REGISTRAR

REG. NO.

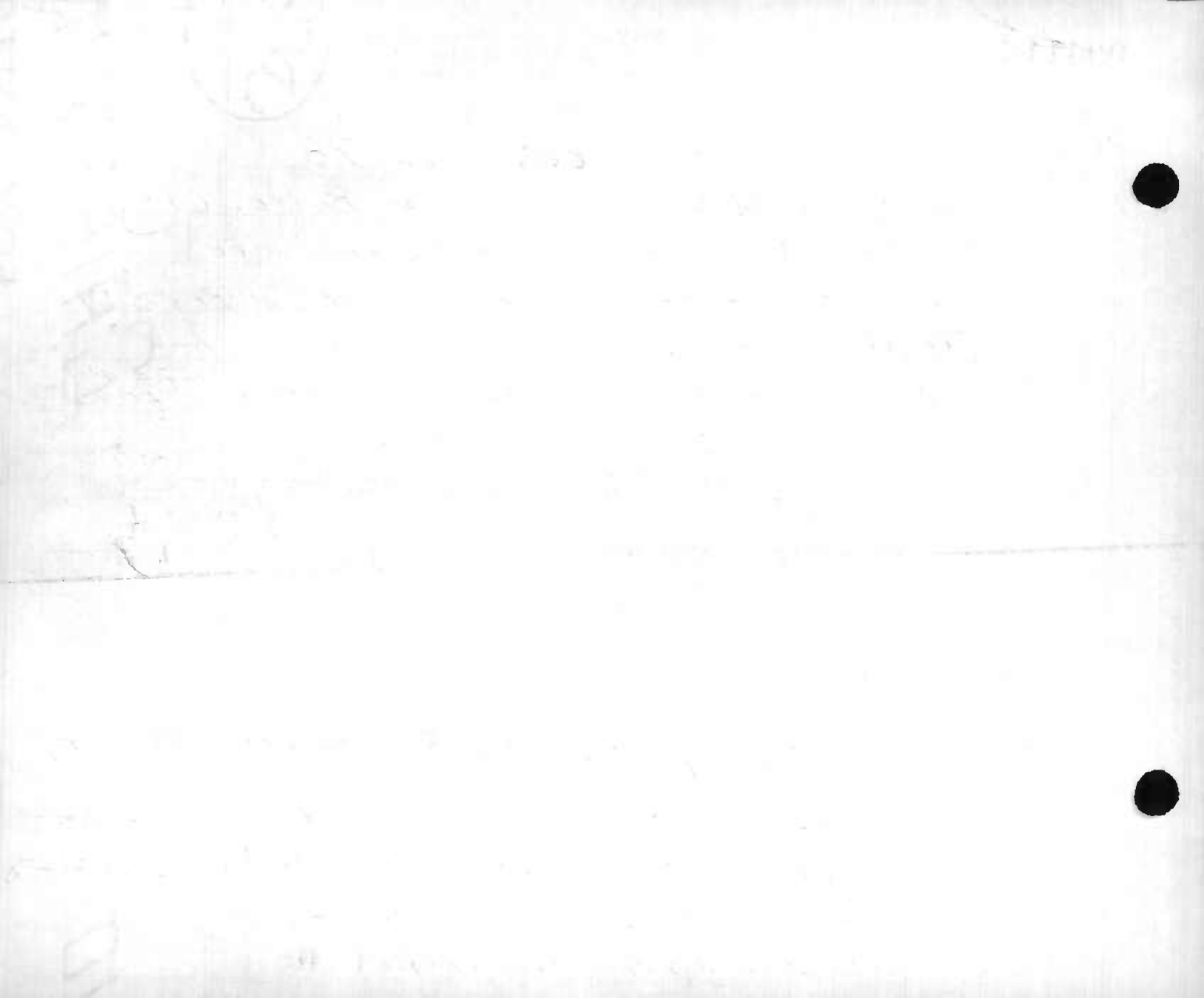
1. DECEASED NAME (TYPE OR PRINT) ANNIE			FIRST MIDDLE LAST NIG Holson			2a. DATE OF DEATH MONTH DAY YEAR 3 29 85				2b. HOUR 8A M	
3. SEX FEMALE		4. RACE NEGRO ID		5. DATE OF BIRTH MONTH DAY YEAR Oct. 15, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Denton Hospital + med center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1307 N. Bond St. 21213		
14. FATHER'S NAME FIRST MIDDLE LAST Tom EATON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST W. Hie unk								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES) 215-22-8529		17. INFORMANT ADDRESS Clara Downes Moore 1223 N. Bond St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperglycemia + sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus + chronic renal</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atrial fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar. 24</u> 19 <u>85</u> , to <u>Mar. 29</u> 19 <u>85</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>Mar. 29</u> 19 <u>85</u> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>J.W. Reed M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/29/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.W. REED M.D.			22e. ADDRESS 6115 CHAS. ST. BALTO MD. 21238								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4-2-85		23c. NAME OF CEMETERY OR CREMATORY ARButus Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.				
24. FUNERAL DIRECTOR NAME Calvin B. Scruggs						ADDRESS 1422 E. Preston		25a. DATE REC'D. BY REGISTRAR APR 1 - 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.



1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>CLARENCE R. NORWOOD</b>			2a DATE OF DEATH MONTH DAY YEAR <b>3 11 85</b>			2b HOUR <b>10<sup>20</sup> AM</b>	
3 SEX <b>MALE</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8 25 1893</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MASON LORDE F.S.K.M.C.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Private Chauffeur</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Dundalk</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Jesse F. Norwood</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret E. Brown</b>		13e STREET ADDRESS / ZIP CODE <b>125 Bayside Drive 21222</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-05-7613 A</b>		17 INFORMANT ADDRESS <b>Anne Norwood 4308 Mainfield Ave. Balto., MD. 21214</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ischemic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>dementia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>chronic alcoholism</b>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>Nov 19 85</b> to <b>Mar 11 19 85</b> , that (I) (we) last saw the deceased alive on <b>Mar 11 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Susan Denman M.D.</b>				DEGREE <b>M.D.</b>		22c DATE SIGNED <b>3/11/85</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Susan Denman</b>				22e ADDRESS <b>5200 Eastern Ave</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>3/15/1985</b>		23c NAME OF CEMETERY OR CREMATORY <b>Pine Grove Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Mt. Airy Maryland</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>				25a DATE REC'D. BY REGISTRAR <b>MAR 14 1985</b>		25b REGISTRAR'S SIGNATURE <b>Susan Denman-Randall</b>	

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer. Page 3 should be filed in the office of the health officer. Page 4 should be filed in the office of the health officer. Page 5 should be filed in the office of the health officer. Page 6 should be filed in the office of the health officer. Page 7 should be filed in the office of the health officer. Page 8 should be filed in the office of the health officer. Page 9 should be filed in the office of the health officer. Page 10 should be filed in the office of the health officer. Page 11 should be filed in the office of the health officer. Page 12 should be filed in the office of the health officer. Page 13 should be filed in the office of the health officer. 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TO THE DIRECTOR, FBI

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FBI  
JAN 10 1964



MEMO

TO THE DIRECTOR, FBI

FROM THE DIRECTOR, FBI

SUBJECT: [Illegible]

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DATE: [Illegible]

BY: [Illegible]

RE: [Illegible]

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BETTY MAY NUCKLES</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>12</b> YEAR <b>85</b>			2b. HOUR <b>12:10 P.M.</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>01</b> DAY <b>14</b> YEAR <b>20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>109 S. FULTON AVENUE, 21223</b>		
14. FATHER'S NAME FIRST <b>UNKNOWN</b> MIDDLE <b>---</b> LAST <b>PRINCE</b>				15. MOTHER'S MAIDEN NAME FIRST <b>GRACE</b> MIDDLE <b>---</b> LAST <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>217-54-4072</b>		17. INFORMANT ADDRESS <b>PATRICIA BUSS 109 S. FULTON AVENUE, 21223</b>					
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Long. Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>3/12</b> , 19 <b>85</b> , to <b>3/13</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/12</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Elmo R. Goyoso</b>						DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3/13/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Elmo R. Goyoso</b>						22e. ADDRESS <b>c/o Bon Secours Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>03-16-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BROOKLYN PK. A.A. MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b> ADDRESS <b>4107 WILKENS AVE.</b>						25a. REC'D. BY REGISTRAR <b>MAR 13 1985</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

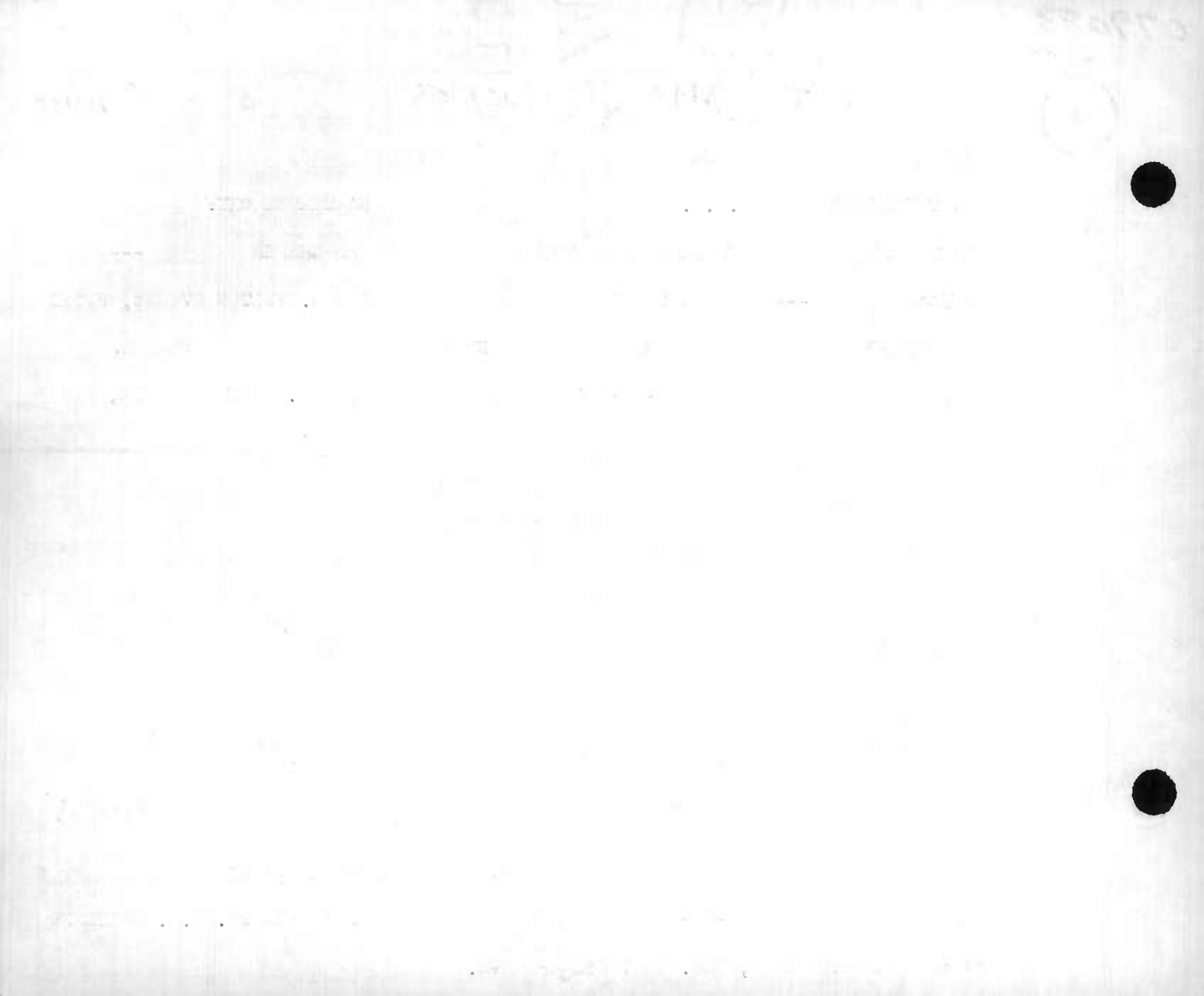
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHJ006735901 ME 21217  
BUTAW M 7/19/85 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edward A Nugent</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 21 85</b>			2b. HOUR <b>6-05 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4/5/1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>36 North Charles General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----0----</b>	
13a. STATE <b>Md.</b>			13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>3603 Lucille Ave. 21215</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Morris Nugent</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude Smith</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes C #26751024</b>					16b. SOCIAL SECURITY NO. <b>220-22-6297</b>		17. INFORMANT ADDRESS <b>Margaret Ford, 3603 Lucille Ave. 21215</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastasis carcinoma of palate</b> DUE TO, OR AS A CONSEQUENCE OF <b>Malnutrition &amp; Dehydration.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  
**Possible Sepsis.**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3-5-1985</b> to <b>3-21-1985</b> , that (I) (we) last saw the deceased alive on <b>3-21-1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R-M. Shah, M.D.</b>				DEGREE		22c. DATE SIGNED <b>3/21/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R-M. SHAH, M.D.</b>				22e. ADDRESS <b>Baltimore, Md. 21218</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/25/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison V.A. Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Owings Mills Md.</b>	
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24. FUNERAL DIRECTOR NAME ADDRESS <b>Law Funeral Home 4611 Park Heights Ave. 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 22 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Lloyd Wesley Nusbaum, SR.</b>			2a. DATE OF DEATH MONTH <b>03</b> DAY <b>06</b> YEAR <b>85</b>			2b. HOUR <b>8:30</b> M <b>M</b>					
3. SEX <b>male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH <b>04</b> DAY <b>08</b> YEAR <b>01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>03</b> DAYS <b>06</b>			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
12. CITY OR TOWN OF DEATH <b>Baltimore City</b>			13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Balto. Gen. Hosp.</b>			14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Captain</b>			15. KIND OF BUSINESS OR INDUSTRY <b>Yacht</b>		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>MD.</b> 16b. COUNTY <b>Balto</b> 16c. CITY OR TOWN <b>Balto</b>			17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			18. STREET ADDRESS / ZIP CODE <b>3737 10th St 21225</b>					
19. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Nusbaum</b> LAST <b>Nusbaum</b>			20. MOTHER'S MAIDEN NAME FIRST <b>Annie</b> MIDDLE <b>Williams</b> LAST <b>Williams</b>								
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			22. SOCIAL SECURITY NO. <b>220-18-5932</b>			23. INFORMANT <b>MARIE E. Nusbaum</b>			24. ADDRESS <b>SAME AS #13</b>		
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture, cardiac papillary muscle</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>											
26. DATE OF OPERATION			27. CONDITION FOR WHICH OPERATION WAS PERFORMED			28. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
33. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			35. LOCATION STREET CITY OR TOWN COUNTY STATE					
36. I certify that (1) (this hospital) attended the deceased from <b>March 4</b> , 19 <b>85</b> , to <b>March 6</b> , 19 <b>85</b> , that (1) (we) last saw the deceased on <b>March 6</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not view the body after death.											
37. SIGNATURE <b>A. Dennis</b>			38. DEGREE			39. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			40. DATE SIGNED <b>3/7/85</b>		
41. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. Dennis</b>			42. ADDRESS <b>3001 S. Hanover St Balto Md 21230</b>								
43. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			44. DATE <b>3-8-85</b>			45. NAME OF CEMETERY OR CREMATORY <b>Security Process, Inc.</b>			46. LOCATION CITY OR TOWN COUNTY STATE <b>Catonville Balt. MD.</b>		
47. FUNERAL DIRECTOR NAME <b>McGully Funeral Home</b>			48. ADDRESS <b>237 E Patapsco Ave Balto MD 21225</b>			49. DATE REC'D. BY REGISTRAR <b>MAR 12 1985</b>			50. REGISTRAR'S SIGNATURE <b>Sa. Davidson-Randall</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07930

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>David</b>				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3 16 1985</b>				2b. HOUR M <b>7:13P</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 1 11</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>74</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3 16 1985</b>	2d. HOUR <b>7:13P</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cemetery</b>	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2813 Matthew St. 21218</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Jensen</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>225-09-7466</b>		17. INFORMANT ADDRESS <b>Mrs. Geraldine Oberholtzer - Same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> .								TITLE (SPECIFY) <b>M.D. Acting Chief</b>	
ACTUAL SIGNATURE <b>Thomas D. Smith</b>		M.D. <b>Acting Chief</b> MEDICAL EXAMINER						DATE SIGNED <b>3/20/85</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M., D.</b>		ADDRESS <b>111 Penn Street, Balto, MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>3/17/85</b>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Anatomy Board Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John R. Randall</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Sophie Oberman		MONTH DAY YEAR 3 12 85		3 A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE	WHITE	MONTH DAY YEAR 7 2 05		79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
RUSSIA	USA			City MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Balt. City	South Balt. Gen. Hospital		XXXXXXX NONE		NONE
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
MD	XXXXXX	BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST SOLOMON OBERMAN		FIRST MIDDLE LAST BESSIE OBERMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		21564 1844		MRS. MARIAN SHUMAN XXXXXXXXXXXXXXXXXXXX 3105 BANCROFT RD. #21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Respiratory Cardiac Insufficiency					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) Hypoxemia, Hyperosmolar Coma					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Sepsis					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 10, 1985, to March 11, 1985, that (I) (we) last saw the deceased alive on March 11, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Paul Warshawsky M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/>		3/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Paul Warshawsky		South Baltimore General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		MAR. 12, 1985		ANSHE NEISEN	
				ROSEDALE BALTO. MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME SOL LEVINSON & BROS., INC.		MAR 14 1985		Davidson-Gondella	
ADDRESS					
6010 REISTERSTOWN RD. BALTO., MD 21215					

3028 COTTON 8002



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH 3 DAY 5 YEAR 85		2b. HOUR 5:00A	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MARY		MIDDLE REBECCA		LAST OBERNDORF	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 12 DAY 17 YEAR 18		6. AGE (IN YEARS LAST BIRTHDAY) 66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION KERNAN Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 1931 WESTCHESTER AVE 21228	
14. FATHER'S NAME FIRST Percy		MIDDLE LeRoy		LAST Sellers		15. MOTHER'S MAIDEN NAME FIRST Mary	
MIDDLE Rebecca		LAST Marchant		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215 10 1900	
17. INFORMANT		Mary Jane Oberndorf		Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic breast Ca to lung DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Hypothyroidism Metastatic Cancer to (R) (L) femur							
19a. DATE OF OPERATION 20 Feb 85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Impending fracture (L) femur		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 20 FEB 19 85 to 5 MAR 19 85, that (I) (we) lost saw the deceased alive on 20 FEB 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE R. Harrington		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5 Mar 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Harrington		22e. ADDRESS Dept. of Orthopedics Kernan Hosp. Balt. MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/8/85		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Md.	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke		P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228		25a. DATE REC'D. BY REGISTRAR MAR 8 1985		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07933  
REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		X MONTH DAY YEAR		2b. HOUR	
JOHN Anthony OFFIDANI								3-10-85		19		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR
Male	White	July 21, 31		53 YRS.					3-10-85		19		11:47A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Baltimore City MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Johns Hopkins Hospital				Labor		Balto. City,					
13a. STATE				13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		Elmwood		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		512 Meadow Rd. 21206			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
John Offidani				Rose Celenzi									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		-----		216-28-0468		John V. Offidani		512 Meadow Rd Baltimore Md 21206					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease													
DUETO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b) DUETO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Margarita A. Korell				M.D. Assistant				3-11-85					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
MARGARITA A. KORELL, M.D.				111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				Mar 13, 85		Gardens of Faith Cem				Baltimore Co., Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Dippel Funeral Homes, Inc.				MAR 12 1985				Davidson					
7110 Belair Rd. Baltimore, Md. 21206													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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25M

BP  
DHMH - 17  
(VR A15 ME (5))

8000

9000 10000 20000

10000 20000 30000 40000 50000 60000 70000 80000 90000 100000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VIVIAN L. OFFORD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-15-85</b>			2b. HOUR M	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-26-15</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>69</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS HOSPITAL</b>				12a. USUAL OCCUPATION (NAME OF WORK FOR MOST OF WORKING LIFE) <b>Beautician</b>	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES WHITE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADA SAUNDERS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>214-20-9062</b>		17. INFORMANT ADDRESS <b>James Offord (Husband) Same AS #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASHD = CEREBRAL VAS DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>diabetes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>uremia - cerebral vas disease</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <b>83</b> to <b>PRESENT</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>15 Mar</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Curtis E Davis</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CURTIS E DAVIS</b>		22e. ADDRESS <b>Bon Secours Hosp 21223</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-21-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Vet. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balt. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>		24b. ADDRESS <b>246 N. Washington Rockville, Md. 20850</b>		24c. DATE REC'D BY REGISTRAR <b>MAR 21 1985</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the funeral director's death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.


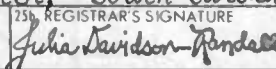
BP

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Film G604 item 5 +  
 FOR  
 1- STATE 6/685 rja  
 REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07935  
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLEO</b>		MIDDLE <b>OGLESBY</b>		LAST <b>OGLESBY</b>		2a. DATE KNOWN OF DEATH ESTIMATED MONTH <b>3</b> DAY <b>31</b> YEAR <b>1985</b>		2b. HOUR <b>7:06</b>	
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>21</b> YEAR <b>1956</b>	6. AGE IN YEARS LAST BIRTHDAY <b>56</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	IF UNDER 24 HRS. MIN <b>0</b>	2c. DATE PRONOUNCED DEAD MONTH <b>3</b> DAY <b>31</b> YEAR <b>1985</b>	2d. HOUR <b>7:06</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3007 Thorndale Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mill Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Garmans Bros.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3603 W. Garrison Ave.</b>	
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Cobb</b> LAST <b>Cobb</b>				15. MOTHER'S MAIDEN NAME FIRST <b>RUTH</b> MIDDLE <b>OGLESBY</b> LAST <b>OGLESBY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>249-38-6125</b>		17. INFORMANT ADDRESS <b>Ernestine Ford 3603 Garrison Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive &amp; arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET <b>111 Penn St., Balto., Md.</b>		CITY OR TOWN <b>Baltimore</b>		COUNTY <b>Calhoun</b>	STATE <b>South Carolina</b>
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>3-31-85</b>		EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-6-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cross Roads Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Westminster, South Carolina</b>		23e. COUNTY <b>Calhoun</b>	
24. FUNERAL DIRECTOR NAME <b>The Bailey - Douglass Funeral Home</b>		ADDRESS <b>1348 North Calhoun St.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 03 1985</b>		25b. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17  
 (VR A15 ME (5))  
 20M 4/B2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "1" there was any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 5 0 7 9 3 6 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1 DECEASED NAME (TYPE OR PRINT) <b>CORNELIUS John O'LEARY, Jr.</b>				MONTH <b>03</b> DAY <b>27</b> YEAR <b>85</b>		2b. HOUR <b>8:05 PM</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH <b>04</b> DAY <b>16</b> YEAR <b>26</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>CITY 2121 MD.</b>	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WYMAN PARK HEALTH SYSTEM</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Air Force</b>	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST <b>CORNELIUS</b> MIDDLE <b>John</b> LAST <b>O'LEARY Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MABLE</b> MIDDLE <b>Viola</b> LAST <b>McFadden</b>		13e. STREET ADDRESS <b>3357 GREENMOUNT AVE &amp; 34th ST 21218</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>219 16 5641</b>		17. INFORMANT <b>Mrs. Bonita Serio Essex, Md. 21221</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Squamous cell cancer of floor of mouth.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Lung &amp; other systemic metastasis.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3-24-85</b> to <b>3-27-85</b> , that (I) (we) lost saw the deceased alive on <b>3-27-85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>A-Y. AKRAWI</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-27-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A-Y. AKRAWI</b>				22e. ADDRESS <b>WYMAN PARK HEALTH SYSTEM.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3/29/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION CITY OR TOWN <b>Baltimore City</b> COUNTY <b>Maryland</b> STATE	
24 FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b> ADDRESS <b>6500 York Rd.</b>				25a. DATE REC'D BY REGISTRAR <b>APR 2-1985</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. Gordon</b>	

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 7 9 3 7

1. DECEASED NAME (TYPE OR PRINT) <b>Mary E Oliver</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 28 1985</b>		2b. HOUR <b>8:00</b>						
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 29 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS HOURS MIN. <b>8:00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, City 21224 MD.</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6117 Cardiff Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Food handler</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>ARA Serv. Food</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6117 Cardiff Ave. 21224</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Smith</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217 22 9038</b>			17. INFORMANT ADDRESS <b>Agnes Raynor 38 S. Randolph Rd 21220</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <b>ACAD S.P. MI CLASS III ANGINA</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 YRS.</b>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>a. CHF 2<sup>nd</sup> to b. Post MI EJECTION FRACTION 25% 2 YRS.</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>COPD</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12</b> , 19 <b>83</b> , to <b>3</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/14</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Burton C. Dlugoff</b>						DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3/28/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BURTON C. DLUGOFF</b>						22e. ADDRESS <b>CAREFIRST - 1005 N. POINT BLVD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4/1/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville Veterans</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Walter Dabrowski</b>						ADDRESS <b>1005 Dundalk Avenue</b>			25. DATE REC'D. BY REGISTRAR <b>APR 2 1985</b>		
						25. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours in the place with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "at work" or "not at work", any injury, or other traumatic event, the medical examiner must be notified.

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03 18 1985 8:00

Oliver

Mary

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White

Female

Baltimore, City 11214

x

USA

Ohio

House-wife

5117 Cardinal Avenue

Baltimore

5117 Cardinal Ave. 11214

x

Baltimore

Maryland

Frances

Sharon

Mary

1117 12 1988 James Raynor 35 S. Kensington Rd 11210

us

Maryland

Baltimore

Crownsville Veterans

4/1/85

Bureau

Water Laboratory 1005 Dumbalk Avenue

0780124

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE FIRST MIDDLE LAST) <b>MARY VERONICA O'LOUGHLIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/16/85</b>		2b. HOUR <b>4:00 AM</b>								
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 30, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DUBLIN, IRELAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>GREAT BRITAIN</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.							
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>EMPLOYMENT COUNSELOR</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRIAL</b>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>						13b. COUNTY <b>21239</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1429 STONEWOOD RD. 21239</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PATRICK JOSEPH O'LOUGHLIN</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>TERESA TIMPSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>----- 214-76-1215</b>		17. INFORMANT ADDRESS <b>ELLEN E. LEWIS 1429 STONEWOOD RD. 21239</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>X</b> IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> , 19 <u>85</u> , to <u>3/16</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/16</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Timothy C. Trageaser</u>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/16/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>TIMOTHY C. TRAGEASER MD</b>				22e. ADDRESS <b>UNION MEMORIAL</b>			

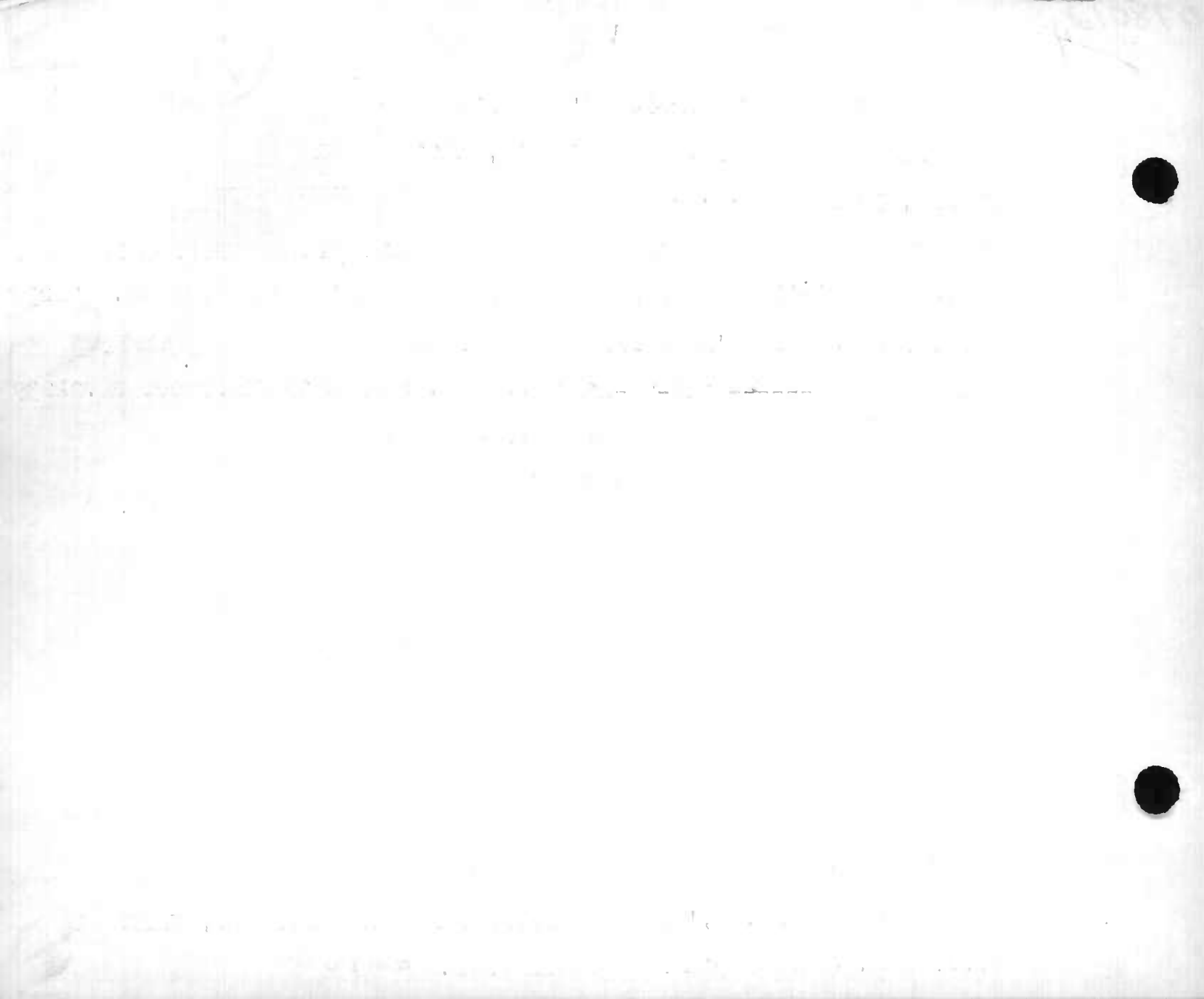
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>CREMATION</b>		23b. DATE <b>MAR. 18, '85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>MAR 18 1985</b> <u>William E. Johnson</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP





086022

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 9 3 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Norma Lorraine Ondeck</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03-20-1985</b>		2b. HOUR <b>5:30p</b> M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 27, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fairlanes</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Julius Freundel</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Delker</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-26-4351</b>		17. INFORMANT ADDRESS <b>John P. Ondeck Jr. Same as # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u><i>Metastatic carcinoma of breast</i></u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u><i>Nutritional cirrhosis of liver</i></u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-6</u> , 19 <u>85</u> , to <u>3-20</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3-20</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u><i>K. Williams</i></u> DEGREE <u><i>W. J. Hicken</i></u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3-20-85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u><i>Kenneth Williams</i></u>				22e. ADDRESS <u><i>SAH. St Agnes Hospital</i></u> <b>Baltimore, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23b. DATE <b>3/23/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Mausoleum</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b> <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the 72 hours after death. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



077009

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8507940

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST HARRY O'NEIL		MONTH DAY YEAR HOUR MAR 12, 1985 8:55 A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
MALE	CAU	MONTH DAY YEAR MAR 14, 1908	76 YRS.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
MD.	U.S.A.		BALTIMORE, CITY MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK AND INDUSTRY)
BALTIMORE CITY	SOUTH BALTIMORE GEN. HSP.		Chip and Corker - Ship Building
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
MD	A.A.	BALTIMORE	YES NO <input checked="" type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS	
FIRST MIDDLE LAST THOMAS O'NEIL	FIRST MIDDLE LAST Annie MARKELL	21225	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	217-05-7959	Hilda Smith	Same as 13e
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>End stage hepatic cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepato-renal syndrome 2° to (a)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Osteitis 2° to (a)</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Le Veer Shunt Operations</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>12 Mar 85</u> to <u>12 Mar 85</u> , that (I) (we) last saw the deceased alive on <u>12 Mar 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
<u>Opie B. Corn, M.D.</u>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	12 Mar 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
<u>Opie B. Corn, M.D.</u>	3001 S. HANOVER, BALTIMORE, MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	3/15/85	Glen Haven Mem Pk	Glen Burnie A.A. Md
24. FUNERAL DIRECTOR		25a. DATE REG'D. BY REGISTRAR	
George J. Gonca 4001 Ritchie Hgwy Balto Md		MAR 14 1985	
		25b. REGISTRAR'S SIGNATURE	
		<u>Carla Gordon-Randall</u>	

MEDICAL CERTIFICATION

29

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07941	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose Mary Oppitz										2a. DATE KNOWN OF DEATH XX 3-6 19 85	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3-6-1900		6. AGE (IN YEARS) 85 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 3-7 19 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 803 N. Chester Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Operator		12b. KIND OF BUSINESS OR INDUSTRY Western Union	
13a. STATE Md.				13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 803 N. Chester St. 21205	
14. FATHER'S NAME FIRST MIDDLE LAST John F. Oppitz						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Steindl					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 216-09-6399		17. INFORMANT ADDRESS Chas. Winkler (nephew) 425 S. Lehigh St. 21224					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 3-7-85			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/11/85		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213						25a. DATE REC'D. BY REGISTRAR MAR 13 1985		25b. REGISTRAR'S SIGNATURE <i>Robert K. ...</i>			

FROM COLLOM RIGER

CHICAGO WITH THE

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>JOANNA M. ORASH</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3-25-85</i>		2b. HOUR M
3. SEX <i>F</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>7-11-1899</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO. CITY</i> MD.	
10. CITY OR TOWN OF DEATH <i>BALTO.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Francis Scott Key Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i> 13b. COUNTY 13c. CITY OR TOWN <i>BALTO.</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>JOHN CZARSKI</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANTOINETTE UNKNOWN</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>219-07-8719</i>		17. INFORMANT ADDRESS <i>MILDRED SEIDENZAHL 7005 HUDSON ST. BALTO. MD. 21224</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Hypertension</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/27</i> , 19 <i>81</i> , to <i>3/25</i> , 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>3/25</i> , 19 <i>85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Jagan L. Chaur MA</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>3/25/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BAHANI B. ELMA MD</i>		22e. ADDRESS <i>3023 Eastern Ave Balto Md 21224</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>3-28-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ST-STANISLAUS CH.</i>	
24. FUNERAL DIRECTOR NAME <i>THOMAS J. SHARDA</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 26 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Jagan Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANK G. OTREMB</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-22-85</b>		2b. HOUR <b>6:10 PM</b>
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>09 21 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STATIONERY ENG.</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>ARBUTUS</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MICHAEL OTREMB</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARYANNA FIBOROF</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW I 214-03-5931</b>		17. INFORMANT ADDRESS <b>VIVIAN P. POSKOCIL 3541 DUDLEY AVENUE, 21213</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>pul. oedema ant. septal M.I.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-20</u> 19 <u>85</u> to <u>3-22</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>3-22</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Stamp</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>3-22-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EDNA S YEO</u>		22e. ADDRESS <u>St Agnes Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>03-27-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>		23e. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Pauline</b> <b>Orcharek</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3/28/85</b>		2b. HOUR <b>11:55 P</b> M	
3. SEX <b>F</b> FEMALE	4. RACE <b>W</b> WHITE	5. DATE OF BIRTH MONTH DAY YEAR <b>4/28/09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Randallstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MAX</b> <b>GROSSBARD</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA</b> <b>ALEXANDER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>053-26-7824</b>		17. INFORMANT <b>MRS. SUSAN RUBY</b> APT. T-2 <b>8601 GRAY FOX RD. RANDALLSTOWN, MD 21133</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma - metastatic</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION <b>No</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>No</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M.</b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/28</b> 19 <b>85</b> , to <b>3/28</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/28</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Rhonda Fiskel MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/28</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rhonda Fiskel MD</b>		22e. ADDRESS <b>Sinai Hospital - Baltimore</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MAR. 31, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH EL MEM. PARK</b>	
23d. LOCATION <b>RANDALLSTOWN</b>		COUNTY <b>BALTO.</b> MD			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 4 1985</b>	
6010 REISTERSTOWN RD. BALTO., MD 21215				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
OVERHOLT, KATHERINE J 901

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>KATHERINE OVERHOLT J OVERHOLT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/9/85</b>		2b. HOUR <b>3:05a.m.</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 10, 1909</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) <b>Baltimore, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>	13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3811 Kimble Road 21218</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Divers H. Jones</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia K. Murdock</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. <b>218 36 0453</b>	17. INFORMANT ADDRESS <b>Mr. Lesley M Overholt 3811 Kimble Road -18</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm above</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cancer - metastatic adenocarcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>2/22 19 85</b> , to <b>3/9 19 85</b> , that (I) (we) lost saw the deceased <b>alive</b> on <b>3/9 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>A. E. Tannen</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/9/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. E. Tannen</b>		22e. ADDRESS <b>Chief of MD Hosp</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/12/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Cdns.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Timonium, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1985</b>			
		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

BP

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Feb. 1, 1963

at 10:00

to the

11:00 AM to 12:00 PM

at 10:00

at 10:00

11:00 AM to 12:00 PM



at 10:00

11:00 AM to 12:00 PM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

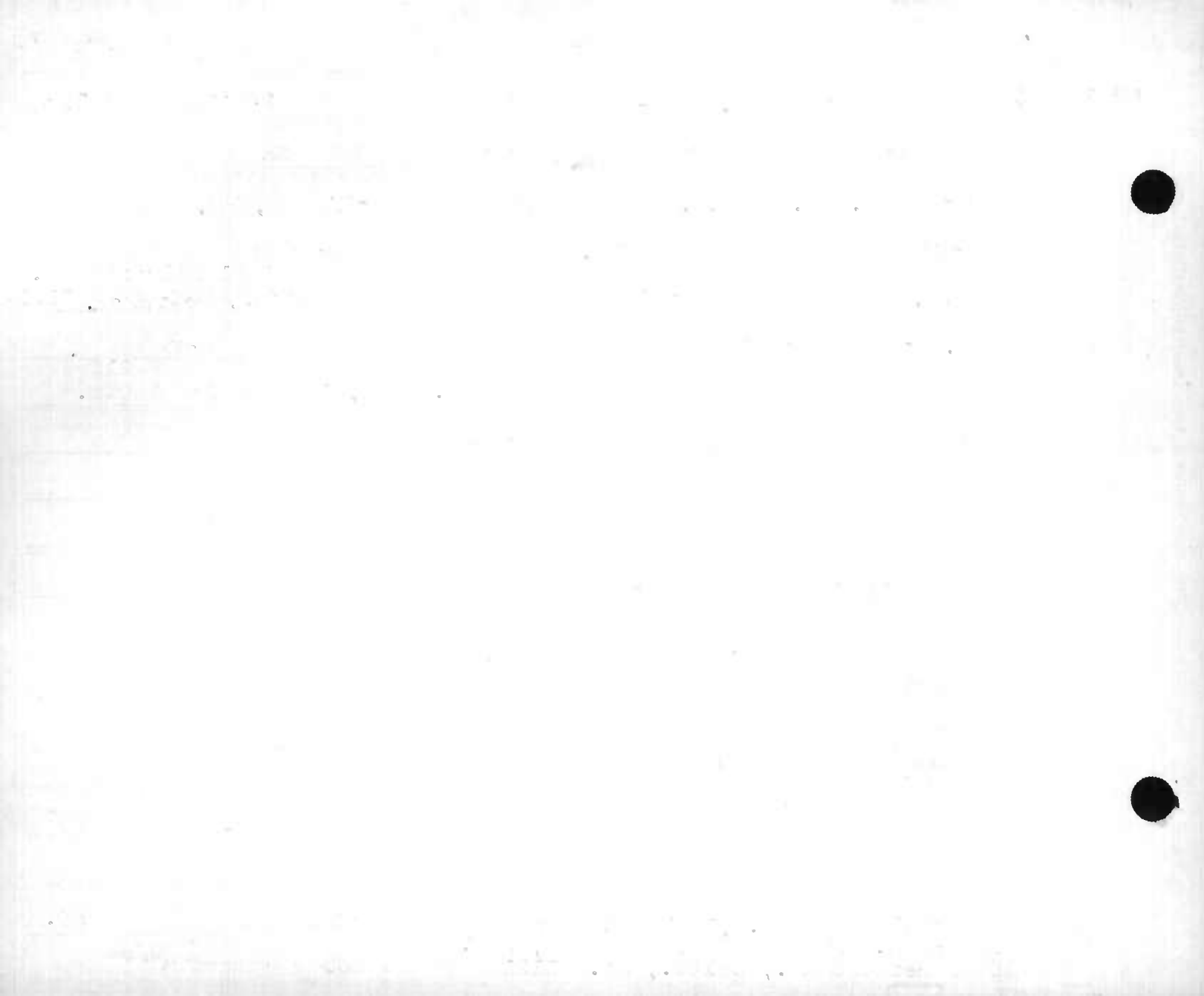
8507946

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Louise H. Page</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/7/1985</b>		2b. HOUR <b>3:30 a.m.</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-21-1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> <del>88</del> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Talbot Co., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, Md.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wesly Home, Inc.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2731 Kildaire Dr.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>J. Camper Harrison</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Heath</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-44-4589</b>		17. INFORMANT ADDRESS <b>Doris V. Page, 1006 Marleigh Cir. 21204</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Strokes</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Signed disorder, Dementia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/25/80</u> , 19____, to <u>3/7/</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/7/85</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert Liberto, M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3-7-85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT LIBERTO, MD</u>		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Mar. 9, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1985</b>		25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>			

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 0 7 9 4 7  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARTHA J PAIGE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-10-85</b>			2b. HOUR <b>3:23 PM</b>				
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 27 21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>				
12. CITY OR TOWN OF DEATH <b>Baltimore</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Medical Ctr.</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>2319 Ruth Avenue 21219</b>			
17. FATHER'S NAME FIRST MIDDLE LAST <b>Anthro Bankhead</b>			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pearl Moore</b>			19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			20. SOCIAL SECURITY NO. <b>213-20-1601</b>	
21. INFORMANT <b>Samuel H. Paige</b>			22. ADDRESS <b>2319 Ruth Avenue</b>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebrovascular Accident</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>24 hours</b> <b>7 days</b>	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Diabetes, Hypertension</b>							
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) <b>NIA</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>NIA</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>March 4, 1985</b> to <b>March 10, 1985</b> , that (I) (we) lost saw the deceased alive on <b>March 10, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Nancy P. Dalos MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/10/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NANCY P. DALOS MD</b>				22e. ADDRESS <b>FRANCIS SCOTT KEY HOSPITAL</b>			

23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3/14/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veteran Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H Inc. 1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1985</b>		25b. REGISTRAR'S SIGNATURE <b>one [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07948

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOMINIC J. PAJARDO			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 3 7 19 85		2b. HOUR M 4:14 P
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 11 22 62	6. AGE (IN YEARS) (LAST BIRTHDAY) 22 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 7 19 85
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2100 blk. Edmondson Ave.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD					
13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 4810 Greencrest Rd. 21206					
14. FATHER'S NAME FIRST MIDDLE LAST Henry Pajardo			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Verneda Alvarez		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Verneda Pajardo 4810 Greencrest Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 4 P.M. 3 7 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Pedestrian struck by train.	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) railroad tracks		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2100 Edmondson Ave., Balto. City Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 3-8-85	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn ST., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/8/85		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD		24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave.			
25a. DATE REC'D. BY REGISTRAR MAR 8 1985		25b. REGISTRAR'S SIGNATURE 			

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080110

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07949

1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE KNOWN OF DEATH				MONTH DAY YEAR				2b. HOUR			
Teirra				Paris				3/15				1985				M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				2d. HOUR			
FEMALE		BLACK		1 15 85		YRS. 2		MONTHS		DAYS		3/15/ 1985				12:07 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
BALTO., MD.				USA								Baltimore City, MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore				University Hospital															
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
MD.								BALTO.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				916 ARLINGTON AVE. 21217			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
LEON				PARIS III				JOYCE				NO				JOYCE SESSOMS 916 ARLINGTON AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u>																			
7680																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?											
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
				M.D. Dep. Chief MEDICAL EXAMINER				3/16/85											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Thomas D. Smith, M.D.				111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL				3/19/85				KING MEM. PK.				BALTO., MD.							
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
LEROY O. DYETT 4600 LIBERTY HGTS. AVE.				MAR 19 1985				John Davidson-Randall											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

090110



UNITED STATES

DEPT. OF COMMERCE

1901-1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) CHARLES F. PARKER, Sr.			2a DATE OF DEATH MONTH DAY YEAR 3 12 85			2b HOUR 2:30A M	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 10 27 19		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD			
10 CITY OR TOWN OF DEATH Baltimore	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, BALTIMORE, MD. 21218			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b KIND OF BUSINESS OR INDUSTRY Own Business	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 2619 Rittenhouse Ave. 21230	
14 FATHER'S NAME FIRST MIDDLE LAST Walter E. Parker, Sr.			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary T. Heffner				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II		16b SOCIAL SECURITY NO. 219-03-6483		17 INFORMANT ADDRESS 21230 Mary L. Parker 2619 Rittenhouse Ave.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>probable sepsis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours
DUE TO, OR AS A CONSEQUENCE OF (b) <u>pseudo monas pneumonia</u>		7-9 days
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASPIRATION</u>		weeks

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (this hospital) attended the deceased from <u>2/1</u> , 19 <u>85</u> , to <u>3/12</u> , 19 <u>85</u> , that <u>X</u> (we) lost saw the deceased alive on <u>3/12</u> , 19 <u>85</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>XX</u> (we) did <u>not</u> view the body after death.						
22b SIGNATURE <u>Ludwig J. Eglseder III MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 3/12/85		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Ludwig J. Eglseder III MD		22e ADDRESS 3900 LOCH RAVEN BLVD. BALTIMORE MD. 21218				

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 3/15/85	23c NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.	23d LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		25a DATE REC'D. BY REGISTRAR MAR 15 1985	25b REGISTRAR'S SIGNATURE <u>Davidson-Rendell</u>





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ADDITIONAL  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 0 7 9 5 1  
CERTIFICATE OF DEATH

093039

REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERNEST H. PARKER				2a. DATE OF DEATH MONTH DAY YEAR 3/27/85		2b. HOUR 104 PM	
3. SEX MALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9-28-65		6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.				13b. COUNTY		13c. CITY OR TOWN BALTIMORE CITY	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Allen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-62-9356		17. INFORMANT 517 N. Pulaski Street Isabelle Allen Baltimore, Maryland 21223			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>ASPIRATION OR RESPIRATORY STAGNATION</u> (c) <u>STATUS EPILEPTICUS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF: <u>STATUS EPILEPTICUS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>CHRONIC RENAL FAILURE</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>27 MAR 1985</u> , to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Curtis E. Paul</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CURTIS E. PAUL				22e. ADDRESS BON SECOURS HOSP. 21223			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/2/1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL HOME OR PERSON TO WHOM FUNERAL HOME, INC. BALTIMORE, MARYLAND 21216				25a. DATE REC'D. BY REGISTRAR MAR 29 1985		25b. REGISTRAR'S SIGNATURE <u>W. J. Henderson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. AIR FORCE

1. The following information is being furnished to you for your information:

2. The following information is being furnished to you for your information:

3. The following information is being furnished to you for your information:

4. The following information is being furnished to you for your information:

5. The following information is being furnished to you for your information:

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13. The following information is being furnished to you for your information:

14. The following information is being furnished to you for your information:

15. The following information is being furnished to you for your information:

16. The following information is being furnished to you for your information:

085061

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07952

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA L PARKS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 18 85</b>			2b. HOUR <b>4:15 P</b>				
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 3 29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secour Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3008 Clifton Ave. 21216</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Parks</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Arra Golden</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>217-22-3152</b>		17. INFORMANT ADDRESS <b>Gordon W. Parks 12 E. Biddle St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest + Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension, Renal Failure &amp;</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Depression, Pneumonia, CHF.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/06</b> , 19 <b>85</b> , to <b>3/18</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/18</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Robert H. Hasenbury</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/18/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert H. Hasenbury</b>						22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/23/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>						ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1985</b>		
						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



0850571

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07953

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
WILLIAM Z. PARLIER, Sr.								3-17-85								M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
MALE	WHITE	6 29 29		55 YRS.						3-17-85						8:40P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		<input checked="" type="checkbox"/> NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH								MD	
N. Carolina		U.S.A.		WIDOWED		DIVORCED		Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		2678 Eagle Street		Auto Mechanic		Bel Air Motors											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2676 Eagle Street		21223							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Clifford		Parlier		Pearl		Brown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		244-40-1325		Mary Parlier		2676 Eagle St.		21223									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a)		Alcoholism and chronic obstructive pulmonary															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		disease															
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Margarita A. Korell, M.D.		Assistant		3-19-85													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
17a. BURIAL, CREMATION, REMOVAL (SPECIFY)		17b. DATE		17c. NAME OF CEMETERY OR CREMATORY		17d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		3/21/85		Crest Lawn Gar. of Mem.		Marriottsville Howard Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Hubbard Funeral Home, Inc.		4107 Wilkens Ave.		21229		MAR 20 1985											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))

20% CO-11-1108

ONE MILLION

1. FOR  
STATE  
REGISTRAR *Zip 21701*STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 7 9 5 4

1. DECEASED NAME (TYPE OR PRINT) <i>ANNIE NAOMI PATTERSON</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 29 85</i>			2b. HOUR <i>12:38 AM</i>			
3. SEX <i>F.</i>		4. RACE <i>B</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 25 11</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>73</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY MD.</i>			
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>UNIVERSITY OF MARYLAND</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>md.</i>		13b. COUNTY <i>U.S.A.</i>		13c. CITY OR TOWN <i>Frederick</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>6121 MANORSWOOD RD/21701</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>EARNEST RIM BUSH</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>JOHNNIE LINDSEY WILLIAMS</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>215-14-1154</i>		17. INFORMANT <i>LINDSEY PATTERSON</i>		ADDRESS <i>1621 MANORWOOD RD</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>A.R.V.S. / PNEUMONIA</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>MOTOR VEHICLE ACCIDENT</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>7 days</i> <i>8 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <i>1) TEMPORAL CONTUSION 2) MULTIPLE ORGAN FAILURE</i>									
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>3 21 1985</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <i>PASSENGER IN M.V.A.</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>STREET</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>RT. 355+26 FREDERICK CO. MD.</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>3/21</i> to <i>3/29</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3/29</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JAMES RUSSELL</i>				22c. ADDRESS <i>M.E. IMSS / UNIV MARYLAND</i>				22d. DATE SIGNED <i>3/29/85</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>4-3-1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>RESTHAVEN mem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>RT 15 Frederick MD</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>C.E. HICKS 1922 Forest Drive, ANNAPOLIS</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 2 1985</i>		25b. REGISTRAR'S SIGNATURE <i>James Harrison</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene. Page 3 should be filed with the funeral director. Page 4 should be filed with the funeral director. IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner or the medical examiner's assistant must sign page 4.

MEDICAL CERTIFICATION

008051

10012

NAME: PATTISON

B 10 22 11 F3

W-2 A

REMARKS: ...

W-2 A

REMARKS: ...

W-2 A

REMARKS: ...

W-2 A

REMARKS: ...

W-2 A

REMARKS: ...

W-2 A

REMARKS: ...

W-2 A

REMARKS: ...

W-2 A

REMARKS: ...



077028

Items 18-22a 5/7/85 mth F#603

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 5

07955

1- STATE REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

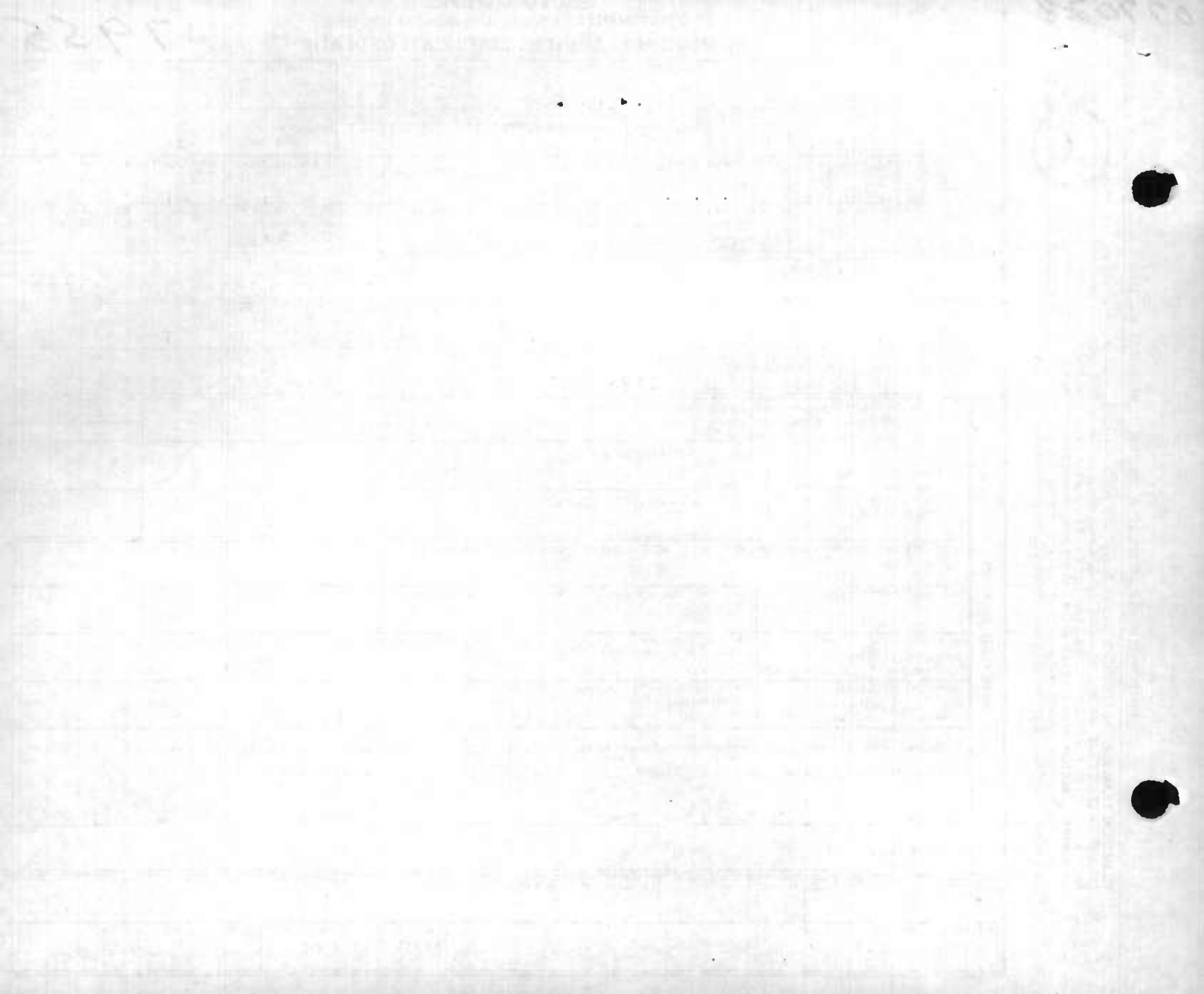
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Mallory						patterson		3		12		19		85		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	Black	10 6 61		23 YRS.						3		12		19		85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										PM	
Maryland		U.S.A.				Baltimore City										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		Johns Hopkins Hospital															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1254 Mapleleaf Ct. 21202									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Clifton		Patterson		Mary		Truss											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		219-76-2068		Mary Patterson		1254 Mapleleaf Ct.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Drowning complicating seizure disorder		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)		DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
		3/12 19 85		subject drpwned in bathtub													
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
		home		1254 Mapleleaf Ct. Baltimore, Md.													
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/>		Accident <input checked="" type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.		ADDRESS		111 Penn Street, Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
BURIAL		3/18/85		Baltimore Cemetery		Baltimore,											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Wm C March F/H, Inc.		1101 E North Ave.				MAR 14 1985		[Signature]									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MDHMH - 17  
(VR A15 ME (5))



VOIDED DEATH CERTIFICATE NUMBER 85-07956

Death April 85



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 07957

1 - FOR  
STATE  
REGISTRAR

REG. NO.

100098

1. DECEASED NAME (TYPE OR PRINT) TDA PAUL			2a. DATE OF DEATH MONTH DAY YEAR 3-31-85			2b. HOUR 7:50 AM			
2. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 15 1890			6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN) BALTO.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTO., CITY MD.		
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVIN DALE Hebrew Geri. Ctr.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker			12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MD.			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES XXXX		
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT SILVERMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-22-3773		17. INFORMANT MRS. HILDA SPECTOR APT. 711 7111 PARK HTS. AVE. BALTO., MD 21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-1, 1985, to 3-31, 1985, that (I) (we) lost saw the deceased alive on 3-31, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature] 22c. DATE SIGNED 3-31-85						22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. ZAWADZKI, MD 22e. ADDRESS Levin Dale Hebrew Geri. Ctr BALTO 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE APR. 1, 1985		23c. NAME OF CEMETERY OR CREMATORY AGUDAS ACHIM ANSHE SFARD		23d. LOCATION ROSEDALE BALTO. MD		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR APR 4 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complies filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18 above, injury, or other traumatic event, the medical examiner must be notified.

100002

DEPT. OF AGRICULTURE

OFFICE OF THE SECRETARY



WASHINGTON, D. C.

SEPTEMBER 10, 1900

TO THE SECRETARY

FROM THE SECRETARY

RE: [illegible]

[illegible]

[illegible]

[illegible]

081357

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8507958

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) RUTH S. Paul			2a. DATE OF DEATH MONTH DAY YEAR 3 1 85			2b. HOUR 3 <sup>20</sup> AM			
3. SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 13 16		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinaï Hospital				12a. USUAL OCCUPATION (TYPE OF BUSINESS OR OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY BALTO. CITY SCHOOLS	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1108 Greenspring Avenue 21209		
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM SAPERSTEIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH BARDOFF						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] NO			16b. SOCIAL SECURITY NO. 217245667		17 INFORMANT MARSHALL PAUL 17 BRICKFORD LANE (21208)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic Failure / Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Breast Carcinoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 2 weeks dx 1983	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ascites, anorexia									
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —				
22a. I certify that (1) (this hospital) attended the deceased from 2/19 19 85 to 3/1 19 85, that (1) (we) last saw the deceased alive on 3/1 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bruce S. Gillies MD					DEGREE MD		22c. DATE SIGNED 3/1/85		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE S. GILLIES					22e. ADDRESS SINAI HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/3/85		23c. NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215					25a. DATE REC'D. BY REGISTRAR MAR 7 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

05/15/57



1. 10/15/57  
2. 10/15/57  
3. 10/15/57  
4. 10/15/57

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10/15/57



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8507960

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Eugene MARTIN Payne			2a. DATE OF DEATH MONTH DAY YEAR 3 5 85			2b. HOUR 3:15 A.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 29 39		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY M.C.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 3315 RAMONA AVE. 21213									
14. FATHER'S NAME FIRST MIDDLE LAST RAYMOND CROCKETT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE PAYNE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.			16b. SOCIAL SECURITY NO. 216-36-6074		17. INFORMANT ADDRESS E. CROCKETT 8003 DELHAVEN RD 21222				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Glenn Bolton					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/5/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Glenn Bolton					22e. ADDRESS 4940 Eastern Ave.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 3-6-85		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE WESTVIEW BALTO. CO. MD			
24. FUNERAL DIRECTOR NAME CHAS. S. ZEILKA + SON INC.					ADDRESS 6227 EASTERN AV.		25a. DATE REC'D. BY REGISTRAR MAR 07 1985		
					25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodell				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



088030

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 07959

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NATALIA A. PAWELCZYK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 30 85</b>		2b. HOUR M <b>-</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUC.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 27 1992</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) <b>POLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3123 O'DONNELL ST.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOME MAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN <b>BALTO</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3123 O'DONNELL ST. 21224</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>- WOZNIAK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>-</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT ADDRESS <b>JEAN MARCINIARK 1827 HANFORD RD 21237</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>-</b> DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 H.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert E. Anderson</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/23/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Anderson</b>		22e. ADDRESS <b>1422 St. Charles Ave 24</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>3/25/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>	
24. FUNERAL DIRECTOR NAME <b>KACZDROWSKI FUNERAL HOME</b>		ADDRESS <b>3525 Fleet St.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Davidson Anderson</b>

BP

DHMH - 16 50M 4/83

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

05-08-20



CHIEF

PO BOX 1001



092063

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 9 6 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
NETTIE B PAYNE			MARCH 27, 1985			01:08am			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
Female	Col. 2	8-15-32	52 YRS.			MONTHS DAYS HOURS MIN.			
8. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Americus, GA.	U.S.A.					BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	THE JOHNS HOPKINS HOSPITAL			Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			
PHILADELPHIA			PENNA			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME (FIRST MIDDLE LAST)			15. MOTHER'S M.AIDEN NAME (FIRST MIDDLE LAST)			13e. STREET ADDRESS / ZIP CODE			
Samuel Hodge			Leema Harvey			1164 E. Stocum St 19150			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
UNKNOWN			264-467441			MARICYNAL PAYNE 1164 E. Stocum St 19150			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Cardio pulmonary Arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 min</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic shock from Pseudomonas Aeruginosa</u> <u>2 days</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aplasia 2° to treatment Acute Myeloid Leukemia</u> <u>14 months</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-3</u> , 19 <u>85</u> to <u>3-27</u> , 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>3-27</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>William M. Russell</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3-27-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William M. Russell</u>						22e. ADDRESS <u>4940 Eastern Ave Balt. MD 21224</u>			
23a. BURIAL, CREMATION, REMOVAL (TYPE)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			4-1-85		Ivy Hill Cem		PHILA PA		
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Vasean L. Russ 2222 WILMINGTON AVE						MAR 28 1985			

MEDICAL CERTIFICATION

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BP

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MADE IN

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DHMH - 16 60M 7/84  
(VRA 15, 4)

093078

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 07962

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>ROBERT PEARCE</b>			2a DATE OF DEATH MONTH DAY YEAR <b>March 17, 1985</b>		2b HOUR <b>11:04p</b>
3 SEX <b>Male</b>	4 RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 9, 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Gen. Contractor</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MD</b>	13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Earleville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>435 Grove Neck Rd 21919</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Marion Earle Pearce, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leona Belle</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 212-22-2522</b>		17 INFORMANT ADDRESS <b>Robert Pearce, Jr. Earleville, MD</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Left ventricular failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>antroseptal MI</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>1 month</b> <b>1 1/2 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>03/02</u> , 19 <u>85</u> , to <u>03/17</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>03/17</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Mindy Shapiro</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/17/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mindy Shapiro</b>		22e ADDRESS <b>Johns Hopkins Hosp.</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>3-21-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Johntown</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Earleville Cecil MD</b>
24 FUNERAL DIRECTOR NAME <b>Fellows Funeral Home</b>		ADDRESS <b>Millington, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1985</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 3 and 25 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (b) or (c), show any injury, or other traumatic event, the medical examiner may be notified.

050820

200 5 2 5 5 5

## DISCUSSION



087044

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8507963

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>LILLY L. de PEDRAGLIO</b>		2a DATE OF DEATH MONTH DAY YEAR <b>MARCH 21, 1985</b>		2b HOUR MIN. <b>11:24 P</b>	
3 SEX <b>Female</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>DEC. 28, 1936</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Peru</b>	7b CITIZEN OF WHAT COUNTRY? <b>Peru</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SIGHT, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE <b>Maryland</b>		13c CITY OR TOWN <b>Rockville</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>11315 Commonweal Drive 20852</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Carlos Lorca</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Manuela Collantes</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b SOCIAL SECURITY NO. <b>NONE</b>		17 INFORMANT ADDRESS <b>Victor Pedraglio, Same as 13</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Grav Negative sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Lymphoma with aplasia</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0 min</b> <b>1 week</b> <b>9 months</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Thrombocytopenia, systemic candidiasis</b>					
19a DATE OF OPERATION <b>3/7</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>3/7</b> 19 <b>85</b> , to <b>3/21</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/21</b> 19 <b>85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.					
22b SIGNATURE <b>D. Royau</b>		DEGREE <b>MD</b>		22c DATE SIGNED <b>3/21/85</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Don Royau MD</b>		22e ADDRESS <b>600 N. WOLFE ST. Johns Hopkins Corp. / Balt, MD 21205</b>			
23a BURIAL, CREMATION, REMOVAL <b>Removal</b>		23b DATE <b>3-25-85</b>		23c LOCATION CITY OR TOWN COUNTY STATE <b>Lima Peru</b>	
24 FUNERAL DIRECTOR NAME <b>DeVol Funeral Home</b>		ADDRESS <b>2222 Wisconsin Ave NW, Washington, DC 20007</b>		25a DATE REC'D BY REGISTRAR <b>MAR 22 1985</b>	
25b REGISTRAR'S SIGNATURE <b>W. Davidson</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filing the funeral certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be filed with the State Dept. of Health and Mental Hygiene.

BP

087044



ST. LOUIS, MO.  
JULY 13 1951

5

2025 COLLECTION

Handwritten notes and stamps, including a large circular stamp in the center. The text is mostly illegible due to fading and bleed-through.

Handwritten notes at the bottom of the page, including the word "Kenny" and other illegible text.

0780158

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8507964

1. DECEASED NAME (TYPE OR PRINT) <b>Charles EDWARD PENN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>03-16-85</b>		2b. HOUR <b>2:08 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07-23-08</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.A. MD.</b>		8. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD		10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore Gen.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OFFICE MGR.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PAINT</b>		13a. STATE <b>MD</b>	
13b. COUNTY <b>U.S.A</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>2900 NEW YORK AVE 21227</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles PENN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SOPHIA KRELL</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-05-8598</b>		17. INFORMANT ADDRESS <b>MRS. IVA C. PENN 2900 NEW YORK AVE 21227</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>H.A.S.C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/12</b> , 19 <b>85</b> , to <b>3-16</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/16</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W. S. Rahman M.D.</b>				22c. DATE SIGNED <b>3/16/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAHMING</b>				22e. ADDRESS <b>3001 S. HANOVER ST. 21230</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/19/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>	
23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>BROOKLYN A.A. MARYLAND</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>AMBROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>J. A. Anderson-Randall</b>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

kin 841-6301

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 7 9 6 5

1. DECEASED NAME (TYPE OR PRINT) Melvin NMI Pennington			2a. DATE OF DEATH MONTH DAY YEAR 3 17 85			2b. HOUR 6:55 AM				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 22 1894		6. AGE (IN YEARS (LAST BIRTHDAY)) 90 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wire Drawer		12b. KIND OF BUSINESS OR INDUSTRY Beth Steel		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Ma					13b. COUNTY Balt.		13c. CITY OR TOWN Balt.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Archie Pennington					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.					16b. SOCIAL SECURITY NO. 213-07-9879		17. INFORMANT 717 Druid Park Lake Drive Lucilla Pennington Apt. 307 Balto. Md. 21217			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Sepsis

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 day

DUE TO, OR AS A CONSEQUENCE OF

Dehydration

1 WK.

DUE TO, OR AS A CONSEQUENCE OF

Metastatic Prostatic Ca

1977

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

CHF, ASCVD, COPD, Alcoholic Liver Disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>November 19, 84</u> to <u>March 17, 19 85</u> , that (I) (we) last saw the deceased alive on <u>March 17, 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Angela L. Corbin, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-17-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANGELA CORBIN				22e. ADDRESS Univ. of Md. Hosp.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/21/1985		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL HOME NAME ADDRESS Nutter & Sons 2501 Gwynns Falls Parkway Funeral Home, Inc. Baltimore, Maryland 21216				25a. DATE REC'D. BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOUR MIN.	
Andy — Petrusik		3 17 85		11:06 AM	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	Caucasian	MONTH DAY YEAR	59	MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
USA (PA)	USA		Baltimore city MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY	
Baltimore	South Baltimore General Hospital		Maintenance	General Motors	
13a STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE		
Maryland	Baltimore	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	817 Seckel Ct, Baltimore, Md 21227		
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
FIRST MIDDLE LAST	FIRST MIDDLE LAST		YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>		
John — Petrusik	Marilyn — MacHuga		yes		
16b SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS		
218269871	patient (chart)		Thelma. M. Petrusik		
18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiac arrest					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c HOW INJURY OCCURRED - (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
	P.M. 19				
21d INJURY OCCURRED	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 3-11-1985 to 3-17-1985, that (I) (we) last saw the deceased alive on 3-17-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b SIGNATURE		DEGREE	22c DATE SIGNED		
Marilyn H. White		MD	3-17-85		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
Marilyn H. White		South Baltimore General Hospital, Baltimore			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION		
Cremation	Mar. 18, 1985	Security Process Crem. Inc.	Catonville, Calto. Co. Md.		
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
McCutly Funeral Home, 130 E. Fort Ave. Balto. Md.		MAR 19 1985		John Davidson-Randall	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN G. PHARR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 / 2 / 85</b>		2b. HOUR <b>5:25<sup>PM</sup></b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 19 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Jordan</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sophia Hill</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-03-1422</b>		17. INFORMANT ADDRESS <b>Viola Jackson 111 N. West St.</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO RESPIRATORY Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **ASHD, ACUTE AORTIC OCCLUSION, RENAL FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>2/27/85</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Aortic iliac Occlusion &amp; Thrombotic</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>FEB 27</b> , 19 <b>85</b> , to <b>MARCH 2</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>MARCH 2</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Stephanie Mason</b> MD.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>3/2/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephanie Mason, MD</b>		22e. ADDRESS <b>Union Memorial Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/7/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b>

24. FUNERAL DIRECTOR  
NAME ADDRESS  
**Wm. C. March F/H 1101 E. North Ave.**

25a. DATE REC'D. BY REGISTRAR  
**MAR 5 1985**  
25b. REGISTRAR'S SIGNATURE  
**Julia Davidson-Randall**

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BALTIMORE CITY

UNION MEDICAL HOSPITAL

BALTIMORE

20% COTTON FIB



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 9 6 8

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>NICHOLAS Andrew PHILLIPS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/5/85</b>		2b. HOUR <b>5<sup>20</sup> A.M.</b>						
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 5, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Co.</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1321 Pentwood Road 21239</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Phillips</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-05-5506</b>		17. INFORMANT ADDRESS <b>Mrs. Angela M. Phillips 1321 Pentwood Rd. 21239</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Large @ pleural effusion, unknown etiology</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>March 1, 1985</b> , to <b>March 5, 1985</b> , that (I) (we) lost saw the deceased alive on <b>March 5, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Lucy J Cairns</b> MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3/5/85</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lucy J Cairns</b>				22e. ADDRESS <b>Union Mem Hosp Baltimore MD 21218</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-8-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>MAR 6 1985</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

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TO THE  
DIRECTOR  
OF THE  
BUREAU OF  
THE  
NAVY  
WASHINGTON  
D.C.

*Very respectfully*

*John D. ...*

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...



...

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 7 9 6 9

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Mary S. Piehlee</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-15-85</b>		2b. HOUR <b>5:00 AM</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3-12-84</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Home Maker</b>		13a. STREET ADDRESS / ZIP CODE <b>1700 Meridene Dr. Apt. 302</b>		13b. ZIP CODE <b>21239</b>	
14. FATHER'S NAME FIRST LAST <b>John Hack</b>		15. MOTHER'S MAIDEN NAME MIDDLE LAST <b>Carrie UNKNOWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>215125605</b>		17. INFORMANT ADDRESS <b>Mrs. Thelma C. Mitchell SAME AS #13.</b>			

18. CAUSE OF DEATH (Enter only one cause per line. For ICD-9, use 001-999.)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-14-85</b> , 19 <b>85</b> , to <b>3-15</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3-15</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>D. Buck, MD</b>	DEGREE	22c. DATE SIGNED <b>3-15-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. Buck, M.D.</b>	22e. ADDRESS <b>South Baltimore General Hospital</b>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>March 19, 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Zion Luth Ch. Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Stemmers Run, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>	ADDRESS <b>1050 York Road</b>	25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1985</b>	25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

020024

Mr. J. Edgar Hoover  
Director  
Federal Bureau of Investigation  
Washington, D. C.  
Dear Sir:

Re: Mrs. J. Edgar Hoover  
C. L. Hoover, Jr.

Enclosed for you are  
two copies of a letter  
dated and captioned as  
above.

Very truly yours,  
J. Edgar Hoover  
Director

Enclosure  
J. Edgar Hoover  
Director  
March 10, 1964  
J. Edgar Hoover  
Director  
March 10, 1964  
J. Edgar Hoover  
Director  
March 10, 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE		MONTH DAY YEAR 3-10-85		4:55 A.M.	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR July 4 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Balto. City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mech. Operator		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2221 Essex Street 21231
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Kulisiewicz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Pręghowski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-01-0002		17. INFORMANT ADDRESS Genevieve Szczepaniuk 437 S. Angelsea St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) S/P Anterior myocardial infarction 1 mo. t Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) COPD					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-10 19 85 to 3-10 19 85, that (I) (we) last saw the deceased alive on 3-10 19 85, and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death.					
22b. SIGNATURE Daniel M. Perlman		DEGREE MD		22c. DATE SIGNED 3/10/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL M. PERLMAN		22e. ADDRESS Francis Scott Key Medical Ctr.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-14-85		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR John M. Weber & Sons Inc. 401 S. Chester St.		25a. DATE REC'D. BY REGISTRAR 11/1/005			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 85 07971			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sophia Ann Pineiro Pinerio				March 2, 1985 1:30P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1905		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY -----			
13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 1807 E. Lombard St 21231							
14. FATHER'S NAME FIRST MIDDLE LAST Novakowski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No				16b. SOCIAL SECURITY NO. 220-12-4522		17. INFORMANT ADDRESS Baltimore, Md. 21221 Richard Praydis 12 B Westway South	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) Nephrotic Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from February 15, 19 85, to March 2, 19 85, that (we) lost saw the deceased alive on March 2, 19 85, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (we) did not							
22b. SIGNATURE William Tan				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM TAN				22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 6, 85		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc. 7110 Belair Rd. Baltimore, Md. 21206				25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 4 1985 [Signature]			

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*Handwritten signature or initials.*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) **OTIS PINNICK**

2a. DATE OF DEATH MONTH **3** DAY **2** YEAR **85** 2b. HOUR **5:02** am

3. SEX **M.** 4. RACE **NEGRO** 5. DATE OF BIRTH MONTH **10** DAY **7** YEAR **21** 6. AGE (IN YEARS LAST BIRTHDAY) **63** YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Md.** 7b. CITIZEN OF WHAT COUNTRY? **U.S.A.** 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH **BALTIMORE** City MD.

10. CITY OR TOWN OF DEATH **BALTO, MD** 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **VAMC BALTIMORE, MARYLAND 21218** 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **LABORER** 12b. KIND OF BUSINESS OR INDUSTRY **CONSTRUCTION**

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE **Md.** 13b. COUNTY **BALTO** 13c. CITY OR TOWN **BALTO** 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13. STREET ADDRESS / ZIP CODE **2533 KIRK AVE 21218**

14. FATHER'S NAME (TYPE OR PRINT) **Joseph PINNICK** 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) **JOANNA WILLIAMS**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **YES** 16b. SOCIAL SECURITY NO. **150643-2846** 17. INFORMANT ADDRESS **DORIS C. PINNICK 2533 KIRK AVE**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **CARDIOPULMONARY ARREST**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }  
DUE TO, OR AS A CONSEQUENCE OF (b) **ADULT RESPIRATORY DISTRESS SYNDROME** DAYS  
DUE TO, OR AS A CONSEQUENCE OF (c) **SEPTIC SHOCK / ASPIRATION PNEUMONIA** DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

**SEIZURE DISORDER**

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 **21** 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION (CITY OR TOWN COUNTY STATE)

22a. I certify that ☒ (this hospital) attended the deceased from **JANUARY 23**, 19 **85**, to **MARCH 2**, 19 **85**, that ☒ (we) lost the deceased alive on **March 2**, 19 **85** and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above ☒ (we) (did) (do) view the body after death.

22b. SIGNATURE **Mitchell H. Weiss MD** DEGREE **MD** ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ 22c. DATE SIGNED **3/2/85**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **Mitchell H. Weiss** 22e. ADDRESS **3700 Loch Raven Blvd. Balt, MD 21218**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **BURIAL** 23b. DATE **3/2/85** 23c. NAME OF CEMETERY OR CREMATORY **GARREAN FOREST VET.** 23d. LOCATION (CITY OR TOWN COUNTY STATE)

24. FUNERAL DIRECTOR (NAME ADDRESS) **Locks FUNERAL HOME 13047 Central** 25a. DATE REC'D. BY REGISTRAR **MAR 5 1985** 25b. REGISTRAR'S SIGNATURE **Davidson-Randall**

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 7 9 7 3

FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LLOYD PAYNE PIPES			2a DATE OF DEATH MONTH DAY YEAR 3 14 85		2b HOUR 10 <sup>10</sup> AM
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 6 1 31	6 AGE (IN YEARS LAST BIRTHDAY) 53	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN) VIRGINIA	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10 CITY OR TOWN OF DEATH BALTIMORE	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ARMED FORCES	12b KIND OF BUSINESS OR INDUSTRY MILITARY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY BALTIMORE 13c CITY OR TOWN CATONSVILLE			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 1202 WESTERLEE PL; APT. T-1 21228	
14 FATHER'S NAME FIRST MIDDLE LAST CHARLES JOHNSON PIPES			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NERVA ANN HENDERSON		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218/28/7147	17 INFORMANT ADDRESS MS. GOLDIE PIPES 1202 WESTERLEE PLACE T-1 CATONSVILLE, MD 21228		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA, SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) SEAMOUS CELL CA OF LUNG APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. 3 days 3 months	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 3/11, 19 85, to 3/14, 19 85, that (I) (we) lost saw the deceased alive on 3/14, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE M. Maciulis		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c DATE SIGNED 3/14/85
22d PHYSICIAN'S NAME (TYPE OR PRINT) M. MACIULIS		22e ADDRESS ST. AGNES HOSPITAL	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 3/16/85	23c NAME OF CEMETERY OR CREMATORY MT. VIEW CEMETERY	23d LOCATION CITY OR TOWN COUNTY STATE MARRIOTTSTVILLE HOWARD MD
24 FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		P.O. BOX 268 ELLICOTT CITY, MD 21043	25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE MAR 20 1985 Julia Davidson-Randall

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WILKINSON  
MOTOR CO. INC.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07974

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Idell Pittman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 15, 1985</b>		2b. HOUR M <b>M</b>				
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 07 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1525 Lester Morton Court</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1525 Lester Morton Ct. 21202</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Willie Pittman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa L. Ward</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Margrea Pittman 1629 N. Gay Street</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>AORTIC STENOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 YRS.</b> <b>10 YRS.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <b>GLAUCOMA, BLINDNESS</b>									
19a. DATE OF OPERATION <b>n/a</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>n/a</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL</b> , 19 <b>75</b> , to <b>FEBRUARY</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>2-20</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>T.A. Trull</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>MARCH 16 1985</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>T.A. TRULL</b>				22e. ADDRESS <b>Johns Hopkins Hospital Baltimore MD 21205</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3/21/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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[Faint, mostly illegible text covering the page, possibly bleed-through from the reverse side. Some words like "1970" are visible at the top.]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

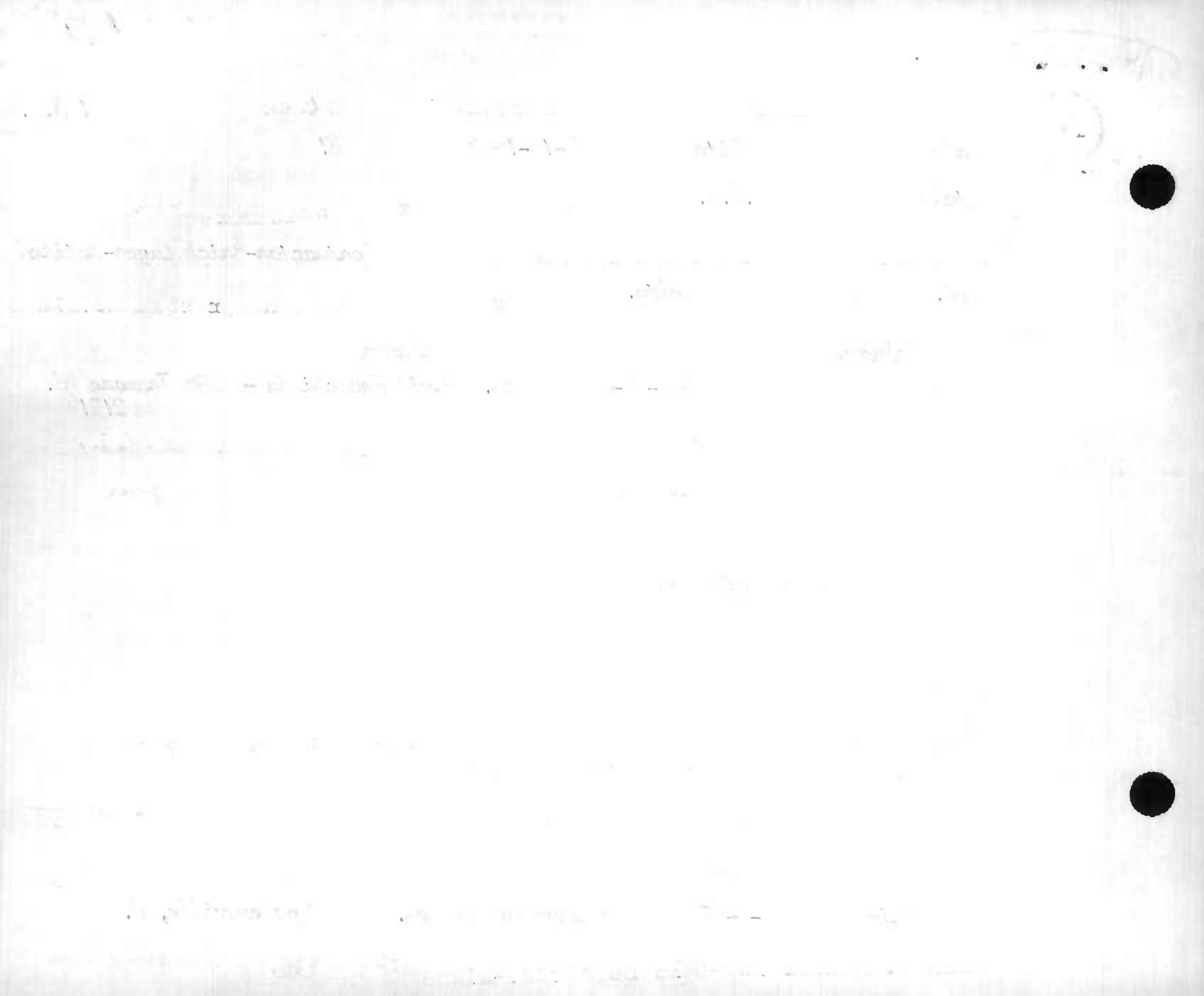
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Gildo Pivetta				3-4-85		1 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male	White	4-19-1903 YEAR		81		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Italy	U.S.A.			Baltimore City MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	4018 Ridgescroft Road			Contractor-Brick Layer		Retired	
13a. USUAL RESIDENCE 1 IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md.		Balt.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4018 Ridgescroft Rd. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Unknown				Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		066-09-5898A		Mrs. Sylvia Franschilla - 6236 Tramore Rd. 21214			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Attack</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCAVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>renal insufficiency</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5-6 days</u> <u>year</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>2-13</u> 19 <u>85</u> to <u>3-3</u> 19 <u>85</u> , that (we) lost saw the deceased alive on <u>2-13</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>George Lowe</u> DEGREE		22c. DATE SIGNED <u>3-4-85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
George Lowe MD		3703 Belair Rd. 21213					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		3-6-85		Dulaney Valley Cem.		Cockeysville, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John C. Miller Inc-6415 Belair Rd.-21206				MAR 5 1985		Julia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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DHMH - 16 60M 7/84  
(VRA 1S, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES F. PIZZA, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAR. 30, 1985</b>			2b. HOUR <b>11:21AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 2. 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bartender</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>639 S. Potomac St. 21224</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Angelo Pizza</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Concetta DiBlasio</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>NW II 213-12-8937</b>		17. INFORMANT ADDRESS <b>Theresa M. Pizza 639 S. Potomac St. 21224</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>probable pulmonary embolism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastatic lung cancer</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>1 hour</b> <b>unknown</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>March 22, 19 85</b> , to <b>March 29, 19 85</b> , that (I) (we) lost saw the deceased alive on <b>March 29, 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robin Cuddy MD</b>						DEGREE		22c. DATE SIGNED <b>3/30/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBIN CUDDY</b>						22e. ADDRESS <b>Johns Hopkins Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>entombment</b>			23b. DATE <b>4/3/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Towson, Baltimore Co. Md</b>		
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc. 5305 Harford Rd. 21214</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 1 - 1985</b>			
						25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

MEDICAL CERTIFICATION

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DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE REGISTRAR *MD*

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <i>Elizabeth Sarah Plack</i>			2a DATE OF DEATH MONTH DAY YEAR <i>3/23/85 3 29 85</i>			2b HOUR MIN. <i>450 A.M.</i>					
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 4 04</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>80</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>0 0 0 0</i>			
7a BIRTHPLACE COUNTRY <i>USA Md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County City MD.</i>					
10 CITY OR TOWN OF DEATH <i>Balt.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Balt Gen. Hosp</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE <i>MD</i>			13b. COUNTY <i>Baltimore</i>			13c. CITY OR TOWN <i>Balt</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>James J. Lean</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Snyder</i>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET ADDRESS / ZIP CODE <i>4103 Brooklyn Ave 21225</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>215-03-4912</i>			17 INFORMANT NAME ADDRESS <i>Melvin G. Adams Westminster, Md. 21157</i>			278 Wintemberry Lane.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio pulmonary Arrest</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure</i>			
								DUE TO, OR AS A CONSEQUENCE OF (c) <i>Septic Shock</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>0</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 10</i> 19 <i>85</i> to <i>March 23</i> 19 <i>85</i> that (I) (we) last saw the deceased alive on <i>March 23</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Sharna</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>3/23/85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Sir, Sharna</i>					22e. ADDRESS <i>South Balt Gen. Hosp 3473200</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>3/26/1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>				
24 FUNERAL DIRECTOR NAME <i>McLuffy Funeral Homes</i>					24b. ADDRESS <i>Baltimore, Md., 21225 237 E. Patapsco Ave.,</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 27 1985</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BERNARD H. PLOTT SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-7-85</b>		2b. HOUR <b>3<sup>50</sup> AM</b>						
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 31 1910</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>74</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 74 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ATTORNEY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STATE OF MD.</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD.</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2728 JEFFERSON ST. 21205</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>HERBERT PLOTT</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELLEN O'BOYLE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-01-0226</b>		17. INFORMANT ADDRESS <b>BERNARD PLOTT JR. (SON) 3417 FOSTER AVE. 21224</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ventilator support</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>CONGESTIVE HEART FAILURE, DIABETES MELLITUS</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (1) (this hospital) attended the deceased from <b>3/7/85</b> to <b>3/7/85</b> that he (we) last saw the deceased alive on <b>3/7/85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (we) did not view the body after death.											
22a. SIGNATURE <b>John F. Carey MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>3/7/85</b>			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John F. Carey</b>				22e. ADDRESS <b>Carey, no Mercy Hospital Baltimore Md 21202</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/11/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>					
24. FUNERAL DIRECTOR NAME <b>SCHIMUNEK FUNERAL HOME, INC.</b>						25a. DATE REC'D. BY REGISTRAR <b>13 MAR 8 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson Handman</b>			
24. FUNERAL DIRECTOR ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marshall W. Pollard			2a. DATE OF DEATH MONTH DAY YEAR March 14, 1985		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 5 23		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5419 Wabash Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST N/A			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N/A		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218-36-2128		17. INFORMANT ADDRESS Betty Pollard 5419 Wabash Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CVD DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CALCIFIED AORTIC VALVE W/ AORTIC INSUFFICIENCY					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/9 19 82 to 3/14 19 85, that (I) (we) lost saw the deceased alive on 3/14 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. Surigave		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 3/20/85		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park Randallstown Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE MAR 18 1985			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H 1101 E. North Avenue		25. DATE REC'D. BY REGISTRAR 25f. REGISTRAR'S SIGNATURE MAR 18 1985			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CAREY C. POLLOCK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 16 85</b>			2b. HOUR <b>8:23a M</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>DECEMBER 18, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC 3900 LOCH RAVEN BLVD 21218</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>(RET)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FEDERAL GOVT.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13c. CITY OR TOWN <b>HARFORD</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>864 ONTARIO STREET 21078</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JESSE POLLOCK</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BESSIE MAE KIRK</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW II 217018118</b>		17. INFORMANT ADDRESS <b>VAMC 3900 LOCH RAVEN BLVD 21218</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>brain stem infarct, renal failure</b> DUE TO OR AS A CONSEQUENCE OF (c) <b>pulmonary embolus</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>FEBRUARY 17</b> , 19 <b>85</b> , to <b>MARCH 16</b> , 19 <b>85</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>MARCH 16</b> , 19 <b>85</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KMETZ</b>			22e. ADDRESS <b>3900 LOCH RAVEN BLVD 21218</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>19MARCH85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANGEL HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HAVRE de GRACE, HARFORD CO., MD.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CATHERINE POOLE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3 21 85</b>		2b. HOUR MIN. <b>5:35 P</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 6, 1913</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Charles General Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maid</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Washington Poole</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Webb</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-34-0737</b>		17. INFORMANT ADDRESS <b>Becky Gooch</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Renal failure, diabetes mellitus, HGI bleed</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> , 19 <u>85</u> , to <u>3/21</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/21</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Veneranda G. Barnes</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>3/21/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>VENERANDA G. BARNES, MD.</u>		22e. ADDRESS <u>NORTH CHARLES GEN. HOSP.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/25/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge, Balto. Co., Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>	
25b. REGISTRAR'S SIGNATURE <u>Jane Davidson-Randall</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Other Countries

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Paul Wade Poole Sr.			2a. DATE OF DEATH MONTH DAY YEAR Mar. 4, 1985			2b. HOUR 1230 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 4, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3217 White Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Serv. Sta. Own.		12b. KIND OF BUSINESS OR INDUSTRY Amoco	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3217 White Ave. 21214	
14. FATHER'S NAME FIRST MIDDLE LAST Wade Poole				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-26-8437A		17. INFORMANT ADDRESS 21214 Patricia M. Poole, 3217 White Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 24, 1975, to Mar. 4, 1985, that (I) (we) last saw the deceased alive on Nov. 21, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R Donald Jandorf M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-4-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R Donald Jandorf			22e. ADDRESS 7403 Harford Rd						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Mar. 6, 1985		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214						25a. DATE REC'D. BY REGISTRAR MAR 6 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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5/22/85 Item 13 L.J

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BABY BOY POORE			2a. DATE OF DEATH MONTH DAY YEAR 3/7/85 HOUR 10:15 PM		
3 SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3/7/85	6 AGE (IN YEARS LAST BIRTHDAY) 0 YRS MONTHS DAYS HOURS MIN.		7b. BALTIMORE CITY OR COUNTY OF DEATH City MD.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A
10 CITY OR TOWN OF DEATH City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND				
13a. STATE MD	13b. COUNTY Cecil Co.	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE 400 Edgar Price Road 21919		
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MIRIAN POORE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NO		17 INFORMANT ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>preterm Delivery</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple Congenital anomalies</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> , 19 <u>85</u> , to <u>3/7</u> , 19 <u>85</u> , that (I) (we) lost <u>above</u> the deceased <u>above</u> (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE David R. Lee MD		DEGREE MD		22c. DATE SIGNED 3/7/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID R. LEE MD		22e. ADDRESS 22 S. Greene St BALTO MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 3/28/85		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR APR 1 - 1985	
				25b. REGISTRAR'S SIGNATURE Julia Davidson	



087130

FOR  
STATE  
REGISTRAR Anna Clara Popko

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07984

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Anna Clara Popko</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3/17/85</b>				2b. HOUR <b>7<sup>25</sup> PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12/11/1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2932 Cornwall Rd. 2nd Floor 21222</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216.10.4416</b>		17. INFORMANT ADDRESS <b>Stacia P. Downing 2932 Cornwall Rd. 1st Flr. 21222</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>?</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3/17/85</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>key medical Center</b>		CITY OR TOWN <b>Baltimore</b>		COUNTY <b>MD</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/17/85</b> , 19 <b>85</b> , to <b>3/20/85</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/17/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Joe Adams MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>3/17/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joe Adams</b>				22e. ADDRESS <b>key medical Center</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/20/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b>			
24. FUNERAL DIRECTOR NAME <b>Walter Brooks Bradley, Inc. Balto., MD</b>				25a. DATE REC'D. BY REG. CLERK <b>VIAR 22 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

REG. NO.

07985

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST REBECCA POSTOFF			2a. DATE OF DEATH MONTH DAY YEAR 3/13/85			2b. HOUR 2:40 AM			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 12 08 06		6. AGE* (IN YEARS LAST BIRTHDAY) XXI 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD.			
10. CITY OR TOWN OF DEATH BALT.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			13e. STREET ADDRESS / ZIP CODE 7000 SURREY DR. 21215			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-46-8587		17. INFORMANT MRS. SHARON SMELKINSON 8710 STEPHANIE RD. RANDALLSTOWN, MD 21133				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b). Electro-Mechanical Dislocation DUE TO, OR AS A CONSEQUENCE OF (c). MYOCARDIAL INFARCTION								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Carcinoma involving both (R) & (L) lungs.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/12/1985, to 3/13/1985, that (I) (we) lost saw the deceased alive on 3/13/1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R.C. Patel					DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/13/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJESH PATEL					22e. ADDRESS SINAL HOSPITAL, BALT. MD-21215				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAR. 15, 1985		23c. NAME OF CEMETERY OR CREMATORY ADATH YESHURUN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 19 1985 [Signature]				

MEDICAL CERTIFICATION

020082

5982



078159

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

FOR  
 1- STATE  
 REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>STANISLAUS STEPHAN POTYRAJ</b>			2a DATE OF DEATH MONTH DAY YEAR <b>03 15 85</b>			2b HOUR <b>8:10 AM</b>					
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>11 9 20</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7a IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		7b IF UNDER 72 HRS HOURS MIN. <b>0 0</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Medical Center</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Baker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Food</b>			
13a STATE <b>Maryland</b>			13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>742 S. Potomac Street 21224</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Stefan Potyraaj</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Honorata Wozniakowski</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Mrs. Evelyn M. Potyraaj</b> <b>742 S. Potomac Street, Baltimore, Md.</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MI</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MI</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>MIDDM, COPD, asthma</b>											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>8/15</b> 19 <b>85</b> , to <b>3/15</b> 19 <b>85</b> , that (1) (we) lost saw the deceased alive on <b>8/15</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Me Soulen</b>					DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/15/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Soulen</b>					22e. ADDRESS <b>Francis Scott Key Med Ctr</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-18-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore Md.</b>				
24 FUNERAL DIRECTOR NAME <b>Ann S. Matthews, 3021 Eastern Ave., Baltimore</b>					ADDRESS <b>Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Richard R. Riddle</b>		

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

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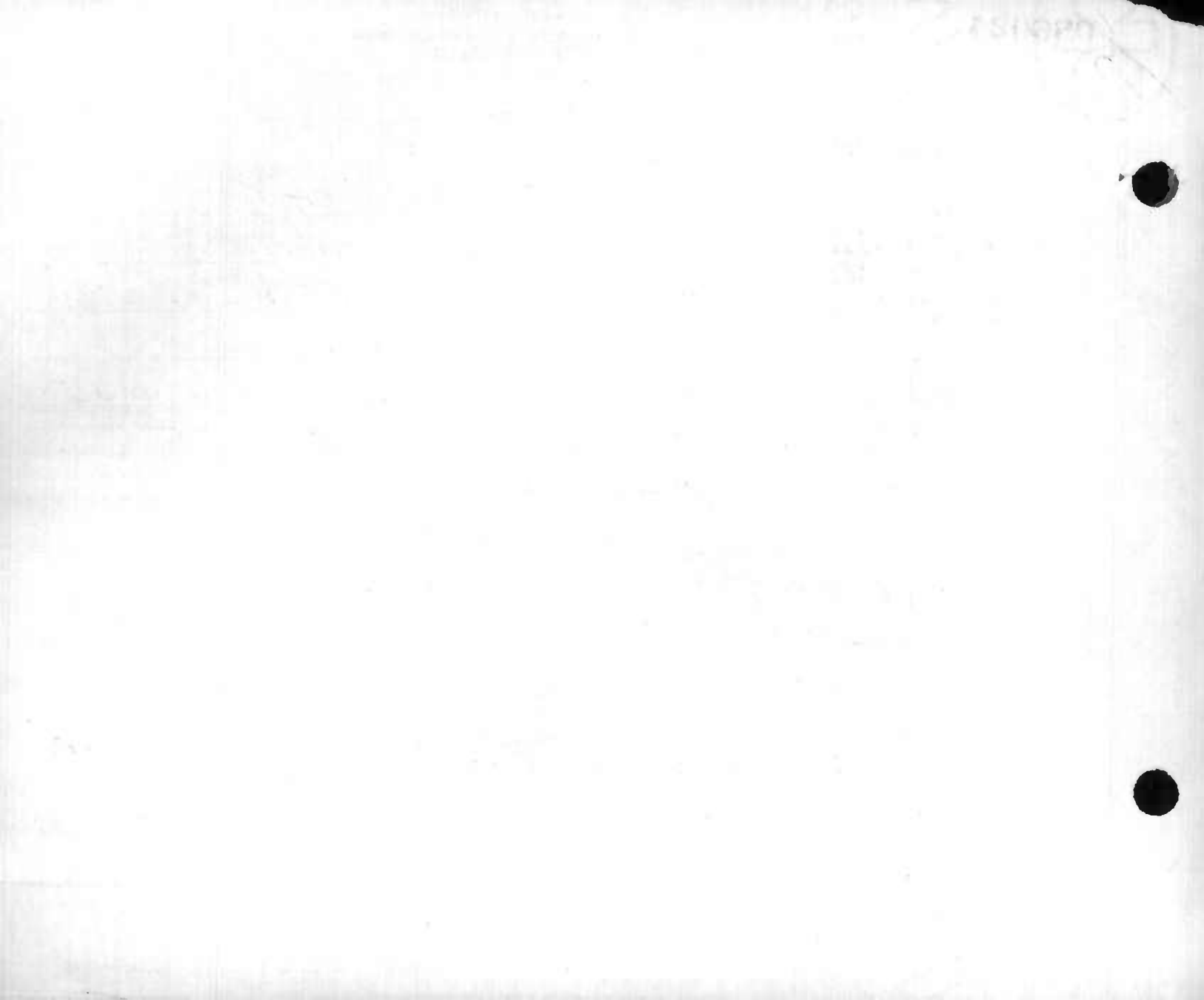
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Barry W. Pave</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 23 85</i>			2b. HOUR <i>11 35 AM</i>			
3. SEX <i>male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 21 1918</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>South Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>City</i> MD.			
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Penton Med Center + Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>RETIRED</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i>			13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown</i>			13e. STREET ADDRESS / ZIP CODE <i>2118 Pennsylvania Ave 21217</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i>			16b. SOCIAL SECURITY NO. <i>450282739</i>		17. INFORMANT ADDRESS <i>Salomon Pave 252 N. Monast.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>coma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>pneumonia</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>dry gangrene of extremities, seizure disorder</i>									
19a. DATE OF OPERATION <i>—</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY
22a. I certify that (I) (this hospital) attended the deceased from <i>20 March 1985</i> to <i>23 March 1985</i> , that the deceased saw the deceased alive on <i>3/23/85</i> 19 <i>85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R. Kolodrubetsky MD</i>					DEGREE		22c. DATE SIGNED <i>3/23/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KOLODRUBETS</i>					22e. ADDRESS <i>102 S Greene St Balt, MD</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>3-28-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GARRISON FOREST</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Garrison Md</i>		
24. FUNERAL DIRECTOR NAME <i>E.L. Phillips</i>					25a. DATE REC'D. BY REGISTRAR <i>MAR 26 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

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Page 1 of 2  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 must be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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VR A 15 (4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				2b. HOUR			
Pearl Frances Powell		3-20-85				6:29 PM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Fem	Col 2	8 16 14		70		YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	USA				Baltto.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltto.		5611 Groveland ave				Housewife			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS									
Md. 13c. Baltto. 13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. 5611 Groveland Ave									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
James Fleet					Sophie Mason				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
		214-03-6782		Theo. R. Powell - 5611 Groveland Ave					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
End stage renal failure									months
Diabetes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/25/85 to 3/20/85, that (I) (we) lost saw the deceased alive on 3/8/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
Kenneth M. Jones MD					3/23/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
K. ZONIES					10807 FALLS RD LUTHERVILLE MD				
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. REGISTRAR'S SIGNATURE	
(SPECIFY)		3/25/85		Woodlawn Cem.		Baltto.		Md.	
Burial									
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR				
Charles H. Powell - 1206 W. North Ave					MAR 28 1985				

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3-10-1941

Final Report

1. The purpose of this report is to provide a summary of the work done during the period from 1-1-41 to 3-1-41. The work was done in the Department of Physics, University of Cambridge, and was carried out by the following persons: [names] and [names].

2. The work was done in the Department of Physics, University of Cambridge, and was carried out by the following persons: [names] and [names]. The work was done in the Department of Physics, University of Cambridge, and was carried out by the following persons: [names] and [names].

3. The work was done in the Department of Physics, University of Cambridge, and was carried out by the following persons: [names] and [names]. The work was done in the Department of Physics, University of Cambridge, and was carried out by the following persons: [names] and [names].

4. The work was done in the Department of Physics, University of Cambridge, and was carried out by the following persons: [names] and [names]. The work was done in the Department of Physics, University of Cambridge, and was carried out by the following persons: [names] and [names].

5. The work was done in the Department of Physics, University of Cambridge, and was carried out by the following persons: [names] and [names]. The work was done in the Department of Physics, University of Cambridge, and was carried out by the following persons: [names] and [names].

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

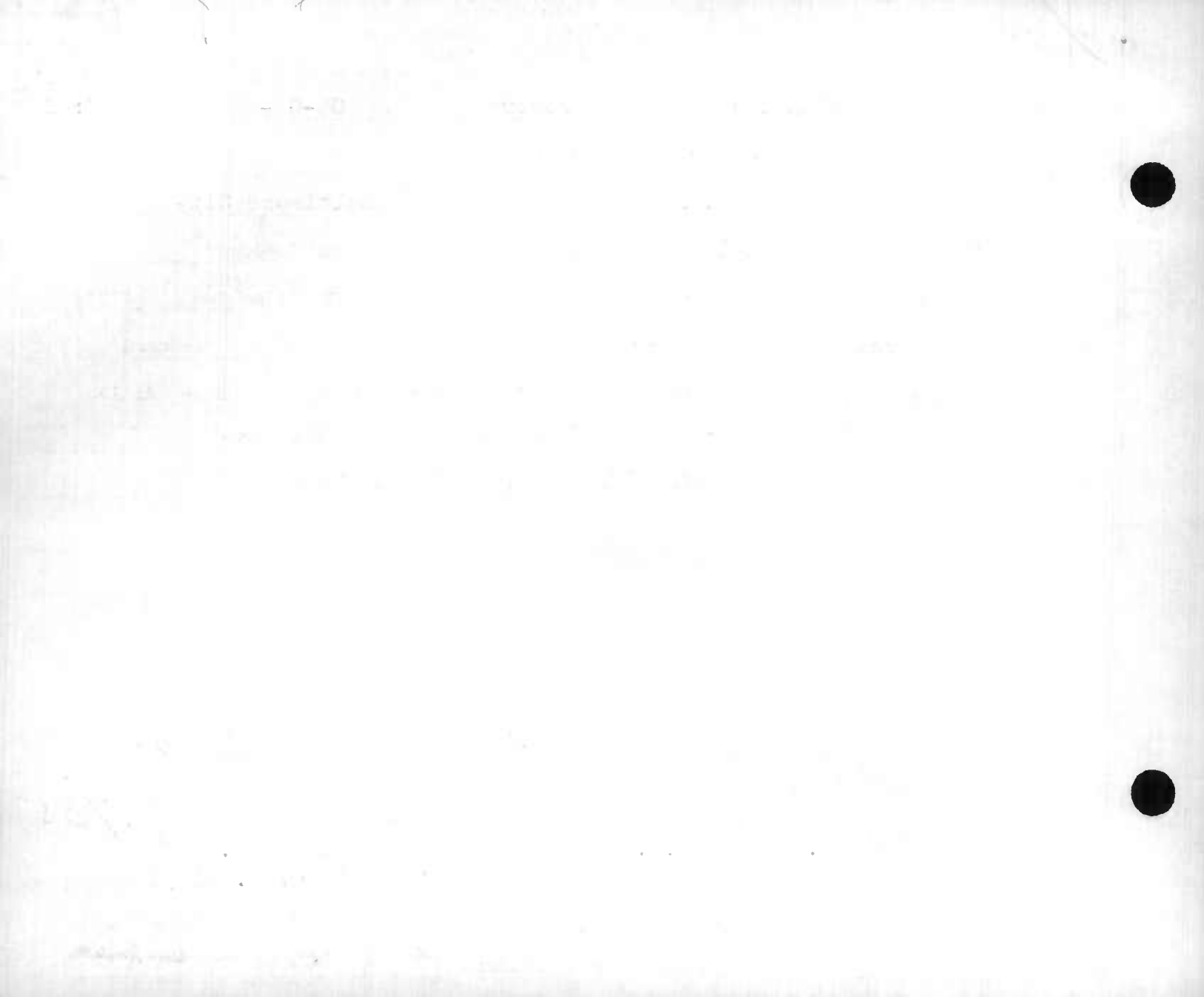
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Adelaide R Powers		03-02-85		9:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	
Female	White	July 7, 1922	62	MONTHS DAYS HOURS MINS	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Belair Convalesarium		Never Employed		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3020 Ailsa Ave 21214	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
William M Powers		Ellen B Leonard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-74-6607		Miss Dorothy Powers Same As 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) CARCINOMA OF COLON					
DUE TO, OR AS A CONSEQUENCE OF (b) WITH METASTASES					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. TIME OF INJURY		20c. HOW INJURY OCCURRED	
(IF EITHER, NOTIFY MEDICAL EXAMINER)		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 19c OR PART II)	
		P.M.			
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. LOCATION	
WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22. I certify that (i) (this hospital) attended the deceased from 2/28/85 to 3/2/85, that (ii) we last saw the deceased alive on 3/1/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (they) did not see the body after death.)					
23a. SIGNATURE		DEGREE		23b. DATE SIGNED	
Luis E. Rivera, M.D.				3/4/85	
24. FUNERAL DIRECTOR		25. ADDRESS		26. DATE REC'D. BY REGISTRAR	
Leonard J Ruck Inc. Baltimore, Maryland		54 Scott Adam Rd. Cockeysville, Md. 21093		MAR 4 1985	
27a. BURIAL, CREMATION, REMOVAL		27b. DATE		27c. NAME OF CEMETERY OR CREMATORY	
Burial		3/6/85		Holy Redeemer	
27d. LOCATION		27e. CITY OR TOWN		27f. COUNTY	
Baltimore, Maryland					
28. FUNERAL DIRECTOR		29. ADDRESS		30. REGISTRAR'S SIGNATURE	
				a. WARDEN HONDA	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be included by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MARY F. PRIBYL.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3-14-85</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 31 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Charles General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Rudolph</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Antonia Smrcina</b>		13a. STREET ADDRESS <b>4003 St. Augustine In 21222</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-34-0075</b>		17. INFORMANT ADDRESS <b>Wm. J. Pribyl Jr. 5920 Clayton Ave. 21206</b>		17b. KIND OF BUSINESS OR INDUSTRY <b>Balto Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congestive heart failure with</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aortic Stenosis.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/31/85</b> to <b>3/14/85</b> , that (I) (we) lost saw the deceased alive on <b>3-14-85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>P.M. Shah m D</b>				DEGREE		22c. DATE SIGNED <b>3/14/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P.M. SHAH.</b>				22e. ADDRESS <b>North Charles General Hospital Baltimore, MD 21218</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-18-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck F.H., inc. 7922 Wise Ave. Balto., Md</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>Mar 18 1985</b>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED - VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR AIS ME (5))FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

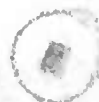
REG. NO.

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1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
Spencer		Prince						DATE OF ESTI- MATED <input checked="" type="checkbox"/> 3/ 18/1985		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	Black	4 07 13		71 YRS.						4:30 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
UNKNOWN		U.S.A.				Baltimore City, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		314 N. Carey Street									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		314 N. Carey Street 21223			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
UNKNOWN				UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
UNKNOWN		726-18-9585		Goliath Bright 314 N. Carey Street							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
<u>Diabetes Mellitus</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
				M.D. Assistant				3/21/85			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Gregory R. Kauffman, M.D.				111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
BURIAL		3/22/85		Mount Zion Cemetery				Lansdowne, County Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Wm C March F/H Inc. 1101 E North Avenue				MAR 22 1985							

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ORA PRYOR</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>March 26, 1985</b>		2b. HOUR <b>3:00 P M</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 1, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE CITY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>	13b. COUNTY	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5900 PARK HGTS. AVE. 21215</b>
14. FATHER'S NAME <b>BALDE</b> MIDDLE <b>WATKINS</b>		15. MOTHER'S MAIDEN NAME <b>ANGELINE</b> MIDDLE <b>WATKINS</b> LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>230-10-1119B</b>		17. INFORMANT <b>WILSON PRYOR</b> ADDRESS <b>5900 PARK HGTS. AVE.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>brainstem CVA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>upper GI bleed</b> <b>ESSENTIAL HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>upper GI bleed</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>upper GI bleed</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>March 21, 1985</b> to <b>March 26, 1985</b> , that (I) (we) last saw the deceased alive on <b>March 26, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE <b>Victoria A. Vanik</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>March 26, 1985</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Victor A. Vanik</b>		22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4/1/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTERN STAR CEM.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>CATONSVILLE, MD.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>LEROY O. DYETT 4600 LIBERTY HGTS. AVE.</b>			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>APR 1 1985</b> <i>Julia Davidson-Rodden</i>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

003135



10/10/10

10/10/10

10/10/10

10/10/10

032140

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 5 07993

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
LOGAN G. PUGH					03-27-85					1030 AM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
M	C		12-11-24		60 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
VA	U.S.A.				BALTIMORE MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		SOUTH BALTIMORE GEN				DUST DGR		BETH STEEL			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE	13c. COUNTY	13d. CITY OR TOWN	13e. INSIDE CITY LIMITS?	13f. STREET ADDRESS / ZIP CODE					
MD				BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1423 Patapsco St.		21230			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
WILLIAM		PUGH		ROSE BEVIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
YES		WW II		226-20-2482		BETTY L. PUGH SAME AS 13e					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY:											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Chronic Obstructive Pulmonary Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Acute Myocardial Infarction</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/20</u> 19 <u>85</u> , to <u>3/27</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/27</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
<u>W. Rahming</u>			M.D.						03/27/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
RAHMING			3001 S. Hanover St. 21230								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL			4/1/85		Md Vets Crownsville		Crownsville AA Co Md.				
24. FUNERAL DIRECTOR NAME			24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
McCully F.H.			BALTO. MD 21230			MAR 29 1985		John Davidson-Randell			

000000



LOGAR C

PHH

15-11-21

C

M

11-2-1

AV



BAIT-1000

DID

11-2-1

BAIT-1000

DID

11-2-1

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

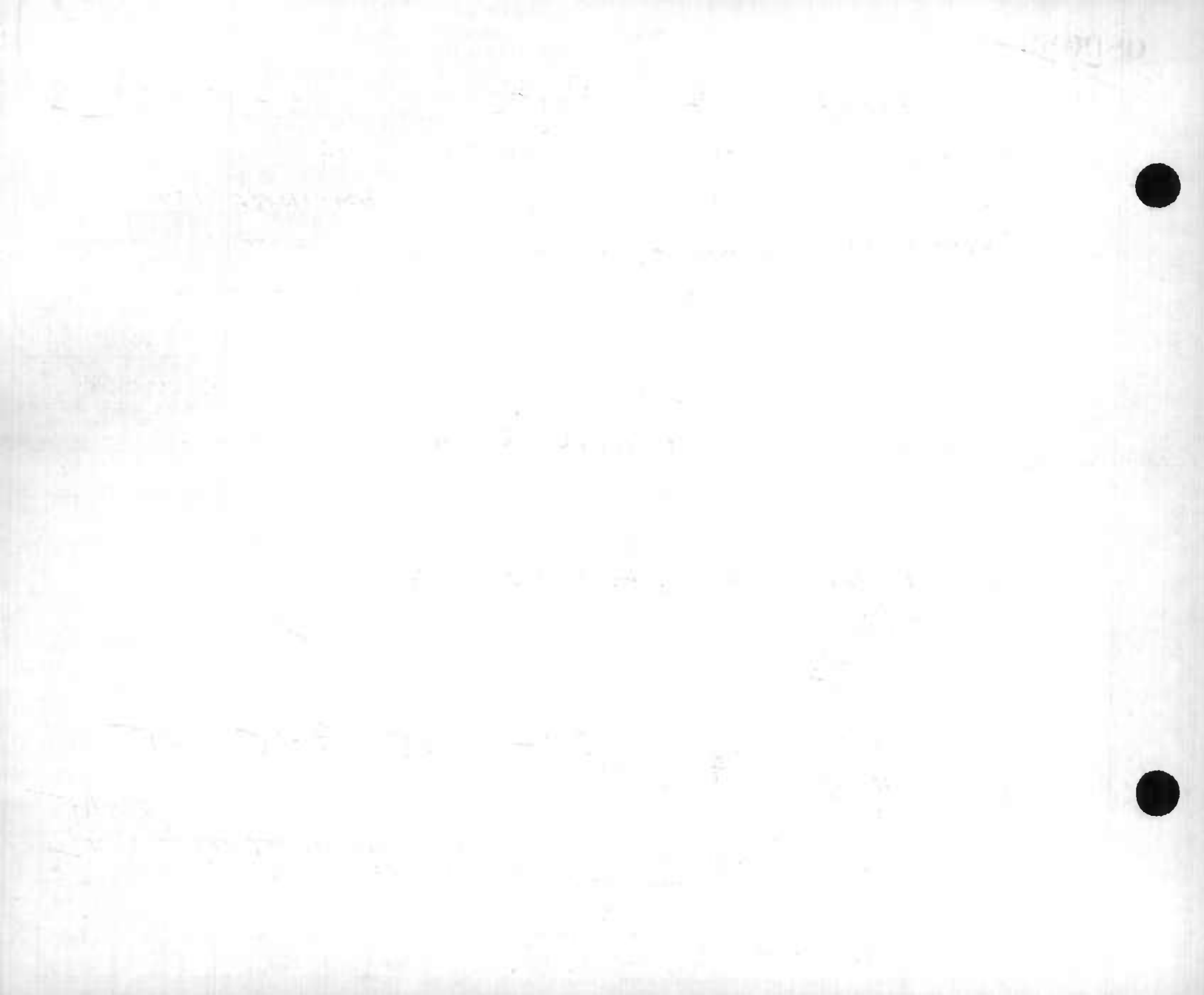
1. DECEASED NAME (TYPE OR PRINT) <b>FLORA</b> <b>FLORA</b>		2a. DATE OF DEATH MONTH <b>3</b> - DAY <b>15</b> - YEAR <b>85</b>		2b. HOUR <b>12</b> <b>AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>3</b> - DAY <b>8</b> - YEAR <b>98</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>87</b> YRS.	
18. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE GOOD SAMARITAN HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSES AIDE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>			
13a. STATE <b>MD.</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST <b>CHARLES</b> MIDDLE <b>FINCH</b> LAST <b>FINCH</b>		15. MOTHER'S MAIDEN NAME FIRST <b>AMANDA</b> MIDDLE <b>VAN</b> LAST <b>VAN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>072-16-0556</b>		17. INFORMANT ADDRESS <b>21224 JOYCE COOK (DGHTR) 8025 GOUGH ST.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC COMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>CONGESTIVE HEART FAILURE</b>					
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-11-85</b> , 19 <b>85</b> , to <b>3-15-85</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3-14-85</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>VUNDYACA V. REDDY</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/15/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VUNDYACA V. REDDY</b>		22e. ADDRESS <b>THE GOOD SAMARITAN HOSPITAL BALTIMORE MD 21239</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/18/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>					
24. FUNERAL HOME NAME <b>SCHIMUNEK FUNERAL HOME, INC.</b> ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>		25a. DATE REC'D. BY REGISTRAR <b>13 MAR 19 1985</b>			
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





094146

5/21/85 Item 13 L.J.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07995

1. DECEASED NAME (TYPE OR PRINT) <b>STEPHAN ALEX PURVIS</b>			2a. DATE OF DEATH MONTH <b>2</b> DAY <b>25</b> YEAR <b>85</b>			2b. HOUR <b>8:07 PM</b>	
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>25</b> YEAR <b>85</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>11</b> <b>06</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY MD</b>	
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI OF BALTO</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>800 Dartmouth Road 21212</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PURVIS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>0</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>PT's chart</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>ANOXIA, RESPIRATORY + METABOLIC ACIDOSIS</b>			
DUE TO, OR AS A CONSEQUENCE OF (c) <b>PREMATURE LUNGS</b>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (us hospital) attended the deceased from <b>2-25-85</b> 19 <b>85</b> , to <b>2-25</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>2-25</b> 19 <b>85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.							
22b. SIGNATURE <b>B. C. Oym MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2-25-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. STEVENS MD</b>				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>2-28-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SINAI Hospital</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>	
24. FUNERAL DIRECTOR NAME <b>SINAI Hospital</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>John E. ...</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

225-230

074009

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Richard Lee Quinn</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 12 1985</b>		2b. HOUR M <b>M</b>
3. SEX <b>Male</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 31 1947</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>37</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Michigan</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>139 N. Kenwood Ave.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Collector</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Antique</b>	
13a. STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Quinn</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna May Murray</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>267-78-1906</b>		17. INFORMANT ADDRESS <b>Jean Quinn 139 N. Kenwood Ave.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Respiratory arrest**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**2 wks**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

**metastatic adenocarcinoma of unknown primary 9 mos**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1984</b> , to <b>MARCH 1985</b> , that (I) (we) last saw the deceased alive on <b>MARCH 6 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.			
22b. SIGNATURE <b>Eric Rowinsky M.D.</b>	DEGREE	22c. DATE SIGNED <b>3-12-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ERIC Rowinsky M.D.</b>	22e. ADDRESS <b>600 N. Wolfe Street</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/15/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Mountain Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Boulder Boulder Colo.</b>
24. FUNERAL DIRECTOR NAME <b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1985</b>	25b. REGISTRAR'S SIGNATURE <b>Lila Davidson-Randall</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

①

079066

UNK.#85-25

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07997

FOR  
1- STATE  
REGISTRAR

REG NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR				26. HOUR	
Cynthia Lee Davis Radford						3-9 1985				M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		21. DATE PRONOUNCED DEAD		27. HOUR	
Female	White	8 28 1963	21 YRS.					3-9 1985		5:08 a. M	
70. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			75. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.			U.S.A.						Baltimore City, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore			University Hospital - STU				Waitress			602 Club	
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland						P.G.		Laurel		3520 Leslie Way #2 20707	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Thomas Davis						Joyce Cummings					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			8007 Allendale Drive Landover, Md. 20785		
No			213-92-4128			Joyce Davis (Mother)					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 10:00PM 3-8 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by auto	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 1 & Gorman Rd., Howard Co., Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 3-9-85	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Gregory B. Kauffman, M.D.		111 Penn St., Balto., Md. 21201			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		3/14/85		Cedar Hill Cemetery		Suitland P.G. Maryland	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25. PREPARED BY REGISTRAR MAR 15 1985 26. REGISTRAR'S SIGNATURE John Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

BP  
DHMH - 17  
(VR A15 ME (5))



COMMUNICATIONS SECTION

UNITED STATES AIR FORCE

FORM 1-60



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN William RAE			2a. DATE OF DEATH MONTH DAY YEAR 3 22 85			2b. HOUR 5:01 <sup>A</sup>			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 4 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY Dock Working	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3739 BROOKLYN AVE 21225 DC	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Exstorn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-05 345		17. INFORMANT Dorothy Rae CH ART		ADDRESS Same as #13 5667	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/16, 19 85, to 3/22, 19 85, that (I) (we) last saw the deceased alive on 3/22, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alfonso A Ortiz				DEGREE		22c. DATE SIGNED 3/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALFONSO A Ortiz				22e. ADDRESS 3001 St Harvett St Baltimore Md 21220			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/25/1985		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard, Md.	
24. FUNERAL DIRECTOR NAME McCully Funeral Homes				25a. DATE REC'D. BY REGISTRAR MAR 27 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	
26. ADDRESS 237 E. Patapsco Ave., Balto., Md., 21225							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

111700





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8507999			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GERTRUDE M. RAMIA</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3/21/85</b>			
3. SEX <b>F</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-12-1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>77</b>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto</b>		8. CITIZEN OF WHAT COUNTRY? <b>MARION F. LORD</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto</b>		10. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto</b>	
11. CITY OR TOWN OF DEATH <b>Balto</b>		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOUSEWIFE</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD.</b>		13b. COUNTY <b>BALTO.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN B. KELLEY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELEANOR BROWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-05-1681</b>	
17. INFORMANT <b>SHARON ANN LORENZ</b>		18. ADDRESS <b>17 PAULA PLACE.</b>		19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. STREET ADDRESS / ZIP CODE <b>1127 S. CLINTON ST. 21224</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. certify that (I) (this hospital) attended the deceased from <b>11/23</b> , 19 <b>81</b> , to <b>3/21</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/21</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE <b>Debra S. Wortham MD</b>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DEBRA S WORTHAM MD</b>		22d. ADDRESS <b>5200 EASTERN AVE</b>		22e. DATE SIGNED <b>3/22/85</b>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3-25-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR <b>HOPFMAN-SKARDA</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. REGISTRAR'S NAME <b>[Name]</b>	

BP

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "I", it shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <u>Joseph P. RANDALL</u>			2a. DATE OF DEATH MONTH <u>03</u> DAY <u>30</u> YEAR <u>85</u>			2b. HOUR <u>1125AM</u>					
3 SEX <u>MALE</u>		4 RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH <u>04</u> DAY <u>13</u> YEAR <u>13</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>71</u> YRS		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.					
10 CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Mercy Hospital, Balto. Md.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Welding Leader,</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Md. Drydock</u>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>Maryland</u>				13b. COUNTY <u></u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>126 E. Clement St. Balto. Md. 21230</u>	
14. FATHER'S NAME FIRST <u>Edward</u> MIDDLE <u></u> LAST <u>Randall</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Anna</u> MIDDLE <u></u> LAST <u>Fuka</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>217-09-8261</u>		17. INFORMANT <u>Mrs. Evelyn G. Randall, Same as above</u>				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>VENTRICULAR TACHY CARDIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ISCHEMIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <u></u> COUNTY <u></u> STATE <u></u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/29</u> 19 <u>85</u> to <u>3/30</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/30</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John F. Carr MD</u>						DEGREE <u></u>		22c. DATE SIGNED <u>3/30/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN CARR</u>						22e. ADDRESS <u>301 ST. PAUL ST. Baltimore 21202</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>April 2, 1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Baltimore,</u> COUNTY <u>Maryland</u> STATE <u></u>				
24. FUNERAL DIRECTOR <u>McClary Funeral Home, 130 E. Fort Ave. Balto. Md. 21230</u>						25a. RECEIVED BY REGISTRAR <u>APR 2 1985</u>		25b. REGISTRAR'S SIGNATURE <u>E. Davidson-Randall</u>			

094021



APR 2 1962

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 0 0 1

REG. NO.

091140

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM REAMER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 21, 1985</b>				2b. HOUR <b>3:37 A.</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 29, 1895</b>		6 AGE (IN YEARS [LAST BIRTHDAY]) <b>90</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6426 ELRAY DR.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AGENT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6426 ELRAY DR. #21209</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH REAMER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JENNIE UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-05-7455</b>		17. INFORMANT ADDRESS <b>MRS. SYLVIA REAMER</b> <b>6426 ELRAY DR. BALTO., MD 21209</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION <b>2/9</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>16</b> , 19 <b>81</b> to <b>death</b> , 19 <b>85</b> , that (I) (we) lost the deceased alive on <b>3/19/85</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>3/21/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>TEROME KOEPEL, M.D.</b>				22e. ADDRESS <b>222 W. COLDSRING LA. BALTO., MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>MAR. 24, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SHOMREI HADATH VE TZEMECH SEDEK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				24b. ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1985</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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20% COTTON FIBER

WELLS FARGO



WELLS FARGO

WELLS FARGO

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES C. RECTOR SR.			2a. DATE OF DEATH MONTH DAY YEAR 3-31-85		2b. HOUR 5:50 AM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 7-04-04-17		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles Street General		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK OR LAST OF WORKING LIFE) Welder		12b. KIND OF BUSINESS OR INDUSTRY Abex Corporation				
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Howard Brooks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucinda Rector		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 219-03-7782A		17. INFORMANT 3114 Normount Avenue Dorothy Rector Baltimore, Maryland 21216		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIO PULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

CARDIOMYOPATHY

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/31/85 to 5/5/85, that (I) (we) last saw the deceased alive on 3/31/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE T. J. INGHAM, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/31/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS N-C-G-H			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/4/1985		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL HOME OR NAME ADDRESS Funeral Home, Inc. Baltimore, Maryland 21216		25a. DATE REC'D. BY REGISTRAR APR 1 - 1985		25b. REGISTRAR'S SIGNATURE L. A. Davidson-Randall			

094082

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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11A North Mt Avenue  
Baltimore, Maryland 21216  
Cot. 101-1101  
11A North Mt Avenue  
Baltimore, Maryland 21216  
Cot. 101-1101  
11A North Mt Avenue  
Baltimore, Maryland 21216  
Cot. 101-1101

11A North Mt Avenue  
Baltimore, Maryland 21216  
Cot. 101-1101  
11A North Mt Avenue  
Baltimore, Maryland 21216  
Cot. 101-1101  
11A North Mt Avenue  
Baltimore, Maryland 21216  
Cot. 101-1101



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic, acute, or other traumatic, acute, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Anthony Reda</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 7, 1985</b>		2b. HOUR <b>11:30 P</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 21, 1928</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>506 S. Macon Street</b>		12a. USUAL OCCUPATION (WORK FOR WHICH HE WAS WORKING LIFE) <b>truck driver and seal</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. ST. <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthony Reda</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Trasatti</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1946-1948 216-24-6051</b>	17. INFORMANT ADDRESS <b>Rosalie Reda, 506 S. Macon St. 21224</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>2/25</b> , 19 <b>85</b> , to <b>3</b> , 19 <b>85</b> , that (I) (we) lost the deceased alive on <b>2/25</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Morton C. Orman</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>3/8/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MORTON C. ORMAN</b>		22e. ADDRESS <b>2936 E. BALTO ST 21226</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3-9-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR <b>Joseph N. Zannino, 263 S. Conkling St. 21224</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1985</b>		

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25b. REGISTRAR'S SIGNATURE  
**John Davidson-Randall**

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

100157

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIOLA Redd		2a. DATE OF DEATH MONTH DAY YEAR 3/30/85		2b. HOUR M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1/5/100		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS
7a. BIRTHPLACE (COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.				
10. CITY OR TOWN OF DEATH BART		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cuthbertson Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker
12b. KIND OF BUSINESS OR INDUSTRY Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE Md	13b. COUNTY BART	13c. CITY OR TOWN BART	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Burley Mayo			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Goode	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 215-32-9581		17. INFORMANT 3323 Brighton Street John T. Redd Baltimore, Maryland 21216

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Anoxia Accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Sept 89 19 89, to 5/30 19 85 that (I) (we) last saw the deceased alive on 3/25 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE [Signature]		DEGREE MD		22c. DATE SIGNED 3/31/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]		22e. ADDRESS 907 BAUTNAH AVE EUMY MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/3/1985	23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland 21043
24. FUNERAL DIRECTOR'S NAME Nutter & Sons Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR APR 4 1985	
25b. REGISTRAR'S SIGNATURE [Signature]			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8005

1. FOR  
STATE REGISTRAR MARY J. REESE

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE JOSEPHINE LAST REESE			2a. DATE OF DEATH MONTH DAY YEAR 3 24 85			2b. HOUR 6:10am	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 2 1914		6. AGE (IN YEARS LAST BIRTHDAY) 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	

13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10729 Midsummer Lane 21044	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Bidun				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Solomie Cerolick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 148-03-9935			17. INFORMANT ADDRESS Eugene Bidun Same as # 13			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Aspiratory Pneumonia	
		DUE TO, OR AS A CONSEQUENCE OF (c) Mental Deterioration	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Wound Infection, Multiple sclerosis

19a. DATE OF OPERATION 3/18/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Extensive Decubitus Ulcers		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1.18. 19 85 to 3 24 19 85, that (I) (we) last saw the deceased alive on 3 24 85 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE		22c. DATE SIGNED 3 24 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Tosimsw M.D.				22e. ADDRESS St. Agnes Hospital, Baltimore, md.			

23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 3/29/85		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE East Hanover New Jersey	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, Md. 21045						25a. DATE REC'D. BY REGISTRAR MAR 27 1985	
						25b. REGISTRAR'S SIGNATURE [Signature]	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP \_\_\_\_\_  
 DHMH - 17  
 (VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08006
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT R. REESE</b>					2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3-10-85</b> 19		2b. HOUR M			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 10, 1955</b>	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>29 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3-10-85</b> 19		2d. HOUR <b>6:04 PM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Forklift Opr.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bottle</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Bel Air</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Edward Reese</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosina Marie Berger</b>			13e. STREET ADDRESS <b>2813 Henley Drive 21014</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>Vietnam</b>		16b. SOCIAL SECURITY NO. <b>214-70-8990</b>		17. INFORMANT ADDRESS <b>Mrs. Carolyn Sue Reese, 2813 Henley Drive Bel Air, Md. 21014</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM MONTH DAY YEAR <b>4:45 PM 3-10-85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver of motorcycle who struck the rear of a pick-up truck</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>hwy.</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Phila. Rd., 224 ft. West of Collium Rd. Balto. C. Maryland</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Margarita A. Korell</i>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>3-11-85</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>			ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Mar. 12, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cratin-Ferris Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>W. Chester Chester Pa.</b>			
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III</b>			ADDRESS <b>Abingdon, Md. 21009</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1985</b>				
						25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				

MEDICAL CERTIFICATION



30% COTTON FIBER

MADE IN THE U.S.A.







11 COLTON ST

WINTERHILL



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 8 0 0 8

FOR  
1- STATE  
REGISTRAR

094037

1. DECEASED NAME (TYPE OR PRINT) <b>Goldin</b> (GOLDEN)		2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> MONTH DAY YEAR <b>3 24 1985</b>		2b. HOUR <b>4:45</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 25 11</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>73</b> YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>IF UNDER 24 HRS.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mexico</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Mexico</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2610 Shirley Ave.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Musician</b>
13a. STATE <b>Md.</b>		13b. COUNTY	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>N/A</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-54-7990</b>		17. INFORMANT ADDRESS <b>Mrs. Mary A. Rei 2610 Shirley Ave</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive &amp; arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Ann M. Dixon, M.D.</b>		TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER		DATE SIGNED <b>3-25-85</b>
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <b>111 Penn St., Balto., Md. 21201</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>4/1/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landsdown Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>William C. March F/H 1101 E. North Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 1 - 1985</b>	25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

550520

1. DECEASED NAME

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
JOHN	P.	REIGHARD	March	27.	1985		11:38a

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	Caucasian	<div> MONTH DAY YEAR </div> Feb 8 1912	73 YRS	MONTHS	DAYS	HOURS	MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY <u>OR</u> COUNTY OF DEATH BALTIMORE CITY
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11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
THE JOHNS HOPKINS HOSPITAL	Manager	Insurance Life

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE Delaware 13b. COUNTY New Castle 13c. CITY OR TOWN Wilmington 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS / ZIP CODE 3603 Hewn Lane, 19808

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
Leo		Reighard	Margaret		Krimm

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17 INFORMANT	ADDRESS
yes	WW II	215 05 3048	Grace A. Reighard, see # 13

<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIO RESPIRATORY ARREST	5 minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	DUE TO, OR AS A CONSEQUENCE OF (b) <u>RENAL FAILURE</u>	<u>2 weeks</u>
	DUE TO, OR AS A CONSEQUENCE OF (c) <u>RUPTURED ABDOMINAL AORTIC ANEURYSM</u>	<u>3 weeks</u>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a DATE OF OPERATION 3/11/85	19b CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Aneurysm	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
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<b>21d. INJURY OCCURRED</b> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	<b>21e. PLACE OF INJURY</b> (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	<b>21f. LOCATION</b> STREET	CITY OR TOWN	COUNTY	STATE
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22a I certify that ☒ (this hospital) attended the deceased from 3/7, 19 85 to 3/27, 19 85, that (I) (we) last saw the deceased alive on 3/27, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

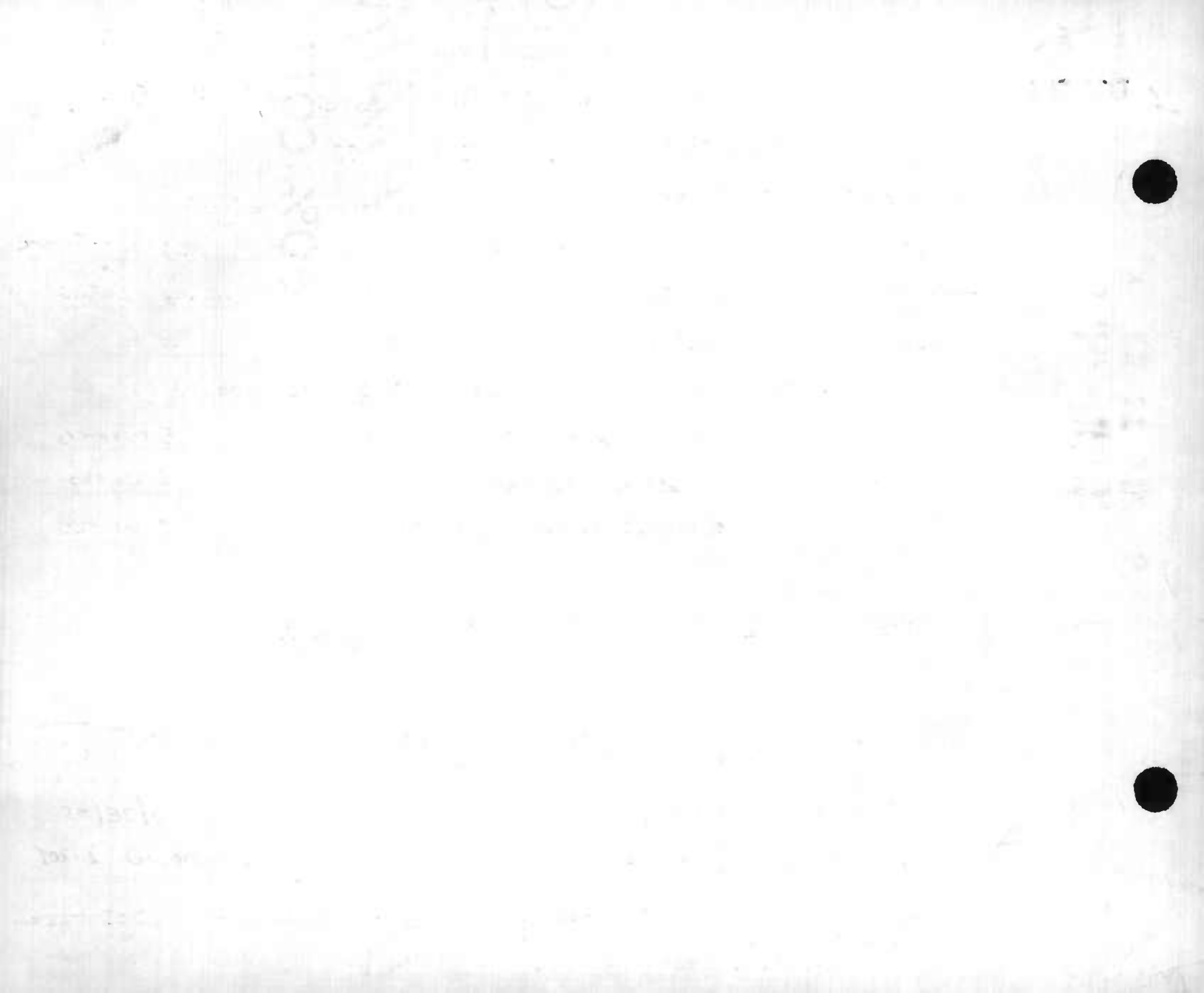
22b. SIGNATURE Peter W. Schlegel MD DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 3/28/05

27d PHYSICIAN'S NAME (TYPE OR PRINT)	27e ADDRESS
PETER N. SCHLEGEL, MD	600 NO. WOLFE ST., BALTIMORE, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	1985 Mar. 30.	Park Silverbrook Memorial	Wilmington		Delaware

24. FUNERAL DIRECTOR NAME	Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.	25a. DATE REC'D. BY REGISTRAR APR 1 1985	25b. REGISTRAR'S SIGNATURE He Davidson-Randall
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DHMH - 16 50M 4/83  
(VRA 15, 4)



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08070							
1- STATE REGISTRAR												2a. DATE KNOWN OF DEATH		2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN RENE												2c. DATE ESTI. MATED		2d. HOUR					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 7 40		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD 3-1-85 19		2d. HOUR 6:52 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer				12b. KIND OF BUSINESS OR INDUSTRY							
14. FATHER'S NAME FIRST MIDDLE LAST unknown												15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No												16b. SOCIAL SECURITY NO. 218-36-9613				17. INFORMANT ADDRESS David Cain 3426 Hickory Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE Margarita A. Korell, M.D. M.D. Assistant MEDICAL EXAMINER												DATE SIGNED 3-2-85							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 3/1/85				23c. NAME OF CEMETERY OR CREMATORY Greenmount				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland							
24. FUNERAL DIRECTOR NAME A. Alan Seitz Jr. 3818 Roland Ave 21211												25a. DATE REC'D. BY REGISTRAR 1 1985				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

2028 COTTON BIRD

WIKIPIA



081004

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1-PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08011	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LINDA Joyce RESH										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 3 14 1985	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 26 1945		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 39	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 14 1985		2d. HOUR 8:35 P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll Co.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (STU)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technician		12b. KIND OF BUSINESS Black & Becker			
13a. STATE Maryland										13b. CITY OR TOWN Manchester	
14. FATHER'S NAME FIRST MIDDLE LAST Chester R. Brown Sr.										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hortense K. Smith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-42-2877		17. INFORMANT Charles K. Resh		ADDRESS 3336 Lineboro Rd. Manchester, Md. 21102		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8160 IMMEDIATE CAUSE (a) Cranio-cerebral trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 6:40 P.M. 3-14-1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto that lost control.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 86 no. of Rt. 30 Carroll Md.							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 3-15-85 EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-18-85		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.					
24. FUNERAL DIRECTOR Thomas D. Fletcher & Son F.H. 254 East Main Street Westminster, Maryland 21157		DATE REC'D. BY REGISTRAR MAR 19 1985		25. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

WINTER  
20% COTTON



0813692

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 8 0 1 2

1 DECEASED NAME (TYPE OR PRINT) TOM ARTHUR REVIS SR.			2a. DATE OF DEATH MONTH DAY YEAR MARCH 5, 1985			2b. HOUR 9:24a M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11-18-1919		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE No. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTIMORE MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Repairman		12b. KIND OF BUSINESS OR INDUSTRY Coast Guard		
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 245 S.Chapel St./21231	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W II		17. INFORMANT ADDRESS Sharon & Nancy Revis/245 S.Chapel St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pancytopenia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 21</u> , 19 <u>85</u> , to <u>March 5</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>March 5</u> , 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Scott A. Berger MD</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>3/5/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Scott A Berger MD</u>					22e. ADDRESS <u>3900 Loch Raven Blvd. Baltimore MD 21218</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE <u>3/8/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crownsville V.A. CEM.</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Anne Arundel Md.</u>		
24. FUNERAL DIRECTOR NAME <u>Lilly &amp; Zeiler Inc.</u>					ADDRESS <u>1901 Eastern Ave.</u>			25a. DATE REC'D. BY REGISTRAR <u>MAR 11 1985</u>		
25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>										

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

021383

20% COTTON LITER

100% COTTON LITER



080038

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thomas Hayne Rice			2a. DATE OF DEATH MONTH DAY YEAR March 16, 1985		2b. HOUR 2:45 P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 12, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver	12b. KIND OF BUSINESS OR INDUSTRY Taxi Cab	
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4 E. 32 Street 21218
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 408-14-1524		17. INFORMANT ADDRESS Baltimore,, Md. Lucille Gott 4008 Marjeff Pl. 21236	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute respiratory failure secondary to</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1. Metastatic adenocarcinoma of lung with brain and bone metastasis. 2. Chronic obstructive pulmonary disease. 3. Arteriosclerotic Cardiovascular Disease.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (s) (this hospital) attended the deceased from <u>March 14, 1985</u> , to <u>March 16, 1985</u> , that (we) lost saw the deceased <u>on</u> <u>March 16, 1985</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (s) (we) (did) <u>not</u> view the body after death.					
22b. SIGNATURE <u>J. Boston</u>		DEGREE <u>MD</u>		22c. DATE SIGNED 3/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Boston M.D.		22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 20, 85		23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Belair, Harford Co., Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Dippel Funeral Homes, Inc. 7110 Belair Rd. Baltimore, Md. 21206		25a. DATE REC'D. BY REGISTRAR MAR 19 1985		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>	

MEDICAL CERTIFICATION

29

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

020022

March 16, 1953

Baltimore

Maryland General Hospital

Baltimore

Respiratory failure secondary to

hemiplegia

1. Hemiplegic paraparesis of lower extremities and partial arm plegia.  
2. Hemiplegic paraparesis of lower extremities and partial arm plegia.

March 16, 1953

March 16, 1953

020022

Maryland General Hospital



085053

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 08014

1. DECEASED NAME (TYPE OR PRINT) <b>John L. Richardson</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>15</b> YEAR <b>85</b>		2b. HOUR <b>10<sup>50</sup> PM</b>
3. SEX <b>M</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH <b>09</b> DAY <b>21</b> YEAR <b>93</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN <b>BALTO</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Samuel</b> MIDDLE <b>A.</b> LAST <b>Richardson</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b></b> LAST <b>Hawkins</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>22003578</b>		17. INFORMANT <b>Marie Johnson</b> ADDRESS <b>Med. Chart 3125 Oakford Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure &amp; Pul. Edema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Seconds</b> <b>DAYS-WKS</b> <b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>	
22a. I certify that (1) (this hospital) attended the deceased from <b>3-15</b> , 19 <b>85</b> , to <b>3-15</b> , 19 <b>85</b> , that (1) (we) lost saw the deceased alive on <b>3-15</b> , 19 <b>85</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Donald R. Taylor MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3-16-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD R. TAYLOR</b>		22e. ADDRESS <b>Dept. Medicine Sinai Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/22/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest VA</b>		23d. LOCATION CITY OR TOWN <b>Owings</b> COUNTY <b>Mills</b> STATE <b>MD</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>		ADDRESS <b>1104 E. North Ave.</b>		25a. DATE RECD. BY REGISTRAR <b>MAR 20 1985</b>	25b. REGISTRAR'S SIGNATURE <b>Handell</b>







086049

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Anna Catherine Ricker</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-23-85</b>		2b. HOUR <b>7<sup>50</sup> AM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 27 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Belair Convalesarium</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>
13a. STATE <b>Md.</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3326 Chesterfield Ave. 21213</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Ceska</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary -</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>214-16-5952</b>		17. INFORMANT ADDRESS <b>Dolores Hess (dghtr) same address</b>	
18. CAUSE OF DEATH (Enter only one cause per box for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIO -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>VASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEVERE CORONARY ARTERY DISEASE</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>SEVERE CORONARY ARTERY DISEASE</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this board) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (and) not view the body after death.					
23a. SIGNATURE <b>RIVERA</b>		DEGREE		23b. DATE SIGNED <b>3/23/85</b>	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RIVERA</b>		23d. ADDRESS <b>5317 BELAIR RD BALTO. MD 21206</b>		23e. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>	
23f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RIVERA</b>		23g. ADDRESS <b>5317 BELAIR RD BALTO. MD 21206</b>		23h. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>	
23i. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23j. DATE <b>3/26/85</b>		23k. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	
23l. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		23m. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>			
24. FUNERAL DIRECTOR NAME <b>Schimunek Funeral Home, Inc.</b>		24b. ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>		25. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

9/9

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE W. RICKETTS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-16-85</b>			2b. HOUR <b>4:25 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 12, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Court Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>918 W. 37th Street 21211</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Edward Ricketts</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Slater Zink</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW 11 215 10 7174</b>		17. INFORMANT ADDRESS <b>Elizabeth F. Ricketts Same</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 MINUTES</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b>		<b>3 WEEKS</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE RENAL AND LIVER FAILURE</b>		<b>3 WEEKS</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3-14 85 3-16 85</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>3-14 85</b> to <b>3-16 85</b> , that (I) (we) lost saw the deceased alive on <b>3-16 85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Charles J. Useroff</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3-16-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES J. USEROFF, M.D.</b>				22e. ADDRESS <b>208 E. BIDDLE ST. BALTIMORE, MD 21202</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>03/19/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville, Balto. Co. Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Burgee-Henss Funeral Home 3631 Falls Rd. 21211</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>			
				25b. REGISTRAR'S SIGNATURE <b>J. Davidson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

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081370

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEOLA O Ricks			2a. DATE OF DEATH MONTH DAY YEAR 3-6-85			2b. HOUR 3:25 PM			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 07 26 23		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ARKANSAS		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.			
10. CITY OR TOWN OF DEATH BALTO. MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired/Urban		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Everet Oliver			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Ferguson			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
17. SOCIAL SECURITY NO. 215-30-5289			18. INFORMANT ADDRESS Noma T. Scott 2207 Baker St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia - carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) cerebrovascular accident									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1-28-1985, to 3-6-1985, that (I) (we) lost saw the deceased alive on 3-6-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Matthew			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Matthew			22e. ADDRESS Lutheran Hospital - 730 Ashbaker St Baltimore						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/11/85		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Bailey Douglass 1348 Calhoun St					25a. DATE REC'D. BY REGISTRAR MAR 11 1985		25b. REGISTRAR'S SIGNATURE Lelia T. Williams		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

BP

02-07-20

BOX COLLON AID

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DAVID RIDDICK			2a. DATE OF DEATH MONTH DAY YEAR 3 15 85			2b. HOUR 930 A	
3. SEX M		4. RACE N		5. DATE OF BIRTH MONTH DAY YEAR 8 4 13		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP of BALTIMORE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed.	
13a. STATE MD		13b. COUNTY Balt		13c. CITY OR TOWN Balt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST David unknown Riddick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta unknown Bell		13e. STREET ADDRESS / ZIP CODE 2912 W COLDSPRING LN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 220 094675		17. INFORMANT ADDRESS Vicki Raab MD Sinai Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c): PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>anoxic encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>overwhelming pneumonia</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>atypical pneumonia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2.12.85</u> , 19 <u>85</u> , to <u>3.15.85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3.15.85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Vicki Ellen Raab MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3.15.85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VICKI RAAB				22e. ADDRESS SINAI HOSPITAL of BALTIMORE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-19-85		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Jas. Morton				25a. DATE REC'D. BY REGISTRAR MAR 18 1985		25b. REGISTRAR'S SIGNATURE J. Lawrence	

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DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					REG. NO.	
1- FOR STATE REGISTRAR					70508019	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Thomas W Riddle</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>3 13 85</u>		
1. SEX <u>M</u>		4. RACE <u>B</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>6 23 40</u>		
7a. BIRTHPLACE (STATE OR FOREIGN) <u>Balto. MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>US</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>44</u> YRS.		
10. CITY OR TOWN OF DEATH <u>Balto.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University Hospital</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore city</u> MD.		
13a. STATE <u>MD</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Thomas Riddle</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary J. Frederick</u>		17. INFORMANT ADDRESS <u>Mollie Alderman 817 Lennox St.</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>UNK</u>		16b. SOCIAL SECURITY NO. <u>217-38-9222</u>		17. INFORMANT ADDRESS <u>Mollie Alderman 817 Lennox St.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>leiomyosarcoma of small bowel</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION <u>2/5/85</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>leiomyosarcoma</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> , 19 <u>85</u> , to <u>3/13</u> , 19 <u>85</u> , that (I) (we) lost <u>now</u> the deceased alive on <u>3/13</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Walter Pagon JR</u>				22c. DATE SIGNED <u>3/13/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WALTER PAGON JR</u>				22e. ADDRESS <u>University Hospital</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3/15/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		
24. FUNERAL DIRECTOR NAME <u>Bailey-Douglass</u>		24b. ADDRESS <u>1348 Calhoun St</u>		25a. DATE REC'D BY REGISTRAR <u>MAR 14 1985</u>		
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				25c. DATE <u>3/15/85</u>		



085054

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

08020

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Richard STEPHEN Rimkevicius								3/ 18/ 19 85								M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
MALE	WHITE	7 6 69		15 YRS.						3/ 18/ 19 85						11:30 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
MARYLAND		U.S.A.		WIDOWED		DIVORCED		Baltimore City,								MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		University Hospital		Student		---											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2005 WILHELM STREET 21223									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
ALGIRDAS RIMKEVICIUS		NANCY SPURLEY															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		N/A		NANCY RIMKEVICIUS		2005 WILHELM ST. 21223											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a)		Gunshot Wound to Face															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)		DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
20. AUTOPSY?																	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		4:10 PM 3/ 18/ 85		subject shot													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
		home		2640 Wilkens Ave., Balto. City, Md.													
22a. I certify that I took charge of the remains described above and that the death resulted from:		Natural causes <input type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Gregory R. Kauffman, M.D.		M.D. Assistant		3/19/85													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Gregory R. Kauffman, M.D.		111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
BURIAL		3/22/85		MEADOWRIDGE MEM. PARK		ELKRIDGE		HOWARD		MARYLAND							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
HUBBARD FUNERAL HOME, INC.		4107 WILKENS AVE.		MAR 20 1985		Davidson-Humell											

07/B4  
25M

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DHMH - 17  
(VR A15 ME (51))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

022024

REGINA MOTION PICTURE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

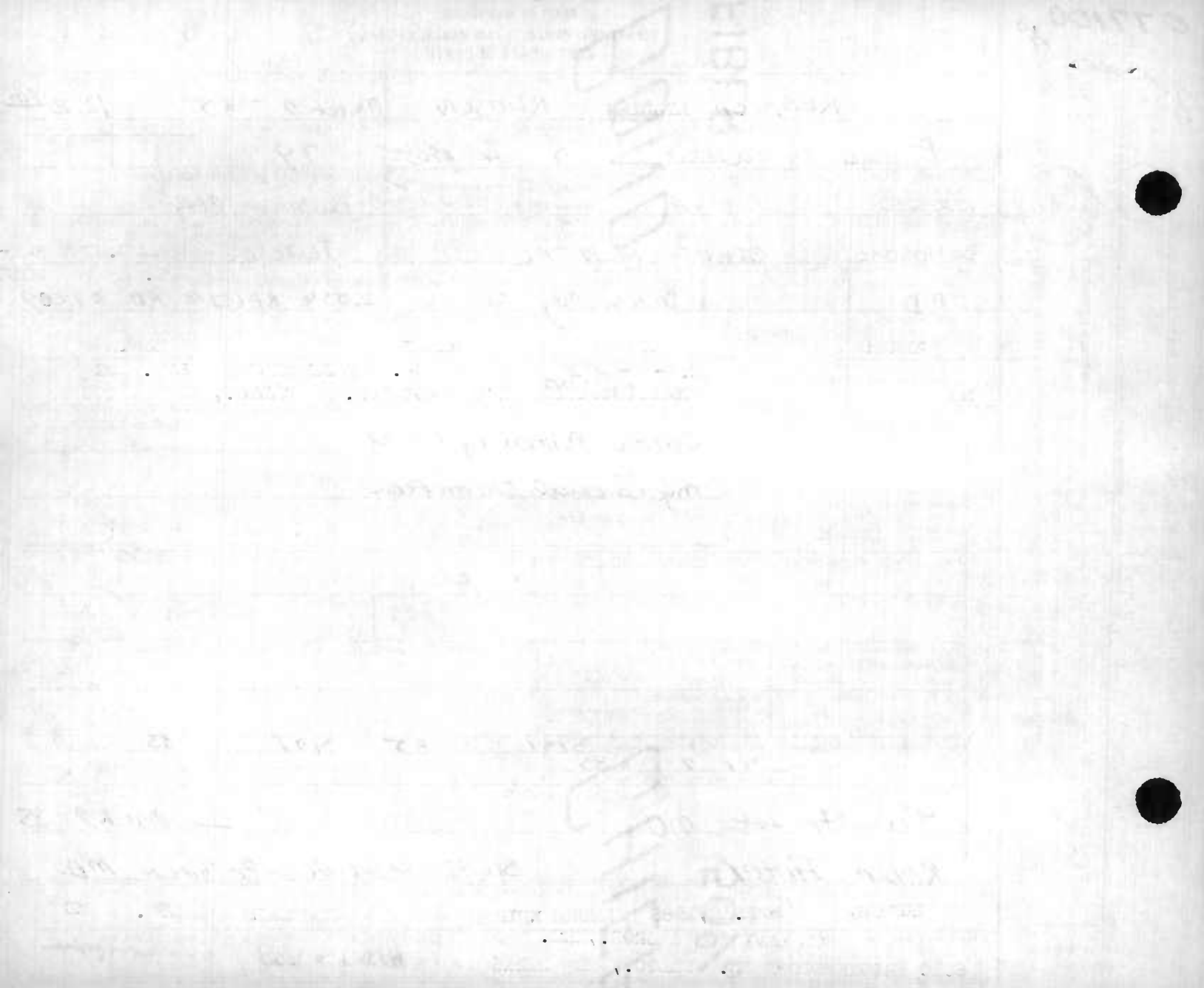
1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>REBECCA LILLIAN RIMSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 7 - 85</b>			2b. HOUR <b>12:20 PM</b>				
3. SEX <b>F FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 4 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79 0</b> YRS		7. UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. CITY SCH-</b>		
13a. STATE <b>MD</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2556 RELLIN RD 21209</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ABRAM</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BELLE LUNTZ</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				
17. INFORMANT <b>MR. ZOLMAN RIMSON</b>			18. ADDRESS <b>130 SLADE AVE. BALTO., MD 21208</b>			19. APT. NO. <b>APT. 202</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/5/85</b> , 19 <b>85</b> , to <b>3/7/85</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/7/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Robin Fintel MD</b>			DEGREE			22c. DATE SIGNED <b>March 7 - 85</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robin Fintel</b>			22e. ADDRESS <b>SINAI HOSPITAL - Baltimore MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>MAR. 10, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANSHE NEISEN</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>		
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>			ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1985</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



081371

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

85 08022

1. DECEASED NAME (TYPE OR PRINT)		FIRST Flora Ellen		MIDDLE R. Ringgold		LAST Ringgold		2a. DATE OF DEATH		MONTH 03	DAY 04	YEAR 85	2b. HOUR 01:30 PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH		MONTH 02		DAY 05		YEAR 03		6. AGE (IN YEARS LAST BIRTHDAY) 8.2 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.								
10. PLACE OF BIRTH (CITY OR TOWN OF DEATH) Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2914 Ridgewood Ave 21215						
14. FATHER'S NAME FIRST Samuel		MIDDLE Ringgold		LAST Ringgold		15. MOTHER'S MAIDEN NAME FIRST Georiana		MIDDLE Carter		LAST Carter				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-82-1902		17. INFORMANT Mrs. Iona Hutton		ADDRESS 2914 Ridgewood Ave 21215								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory / Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic renal failure, hypertension</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Jeannine Saunders		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-4-85								
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Jeannine Saunders		23b. ADDRESS Mercy Hospital												
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d. DATE 3-8-85		23e. NAME OF CEMETERY OR CREMATORY Arbutus Memorial		23f. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md.								
24. FUNERAL DIRECTOR NAME Joseph L Russ		ADDRESS 2222 W. North Ave		25a. DATE REC'D. BY REGISTRAR MAR 6 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandora								

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph W. Robel</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 22, 1985</b>		2b. HOUR M <b>M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 6, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4821 Arabia Ave.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Balt. City Jail</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Robel</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan Schwarzkopf</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 1 214-40-5980</b>		17. INFORMANT ADDRESS <b>Mrs Helen R Robel Same As 13c</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <b>ESOPHAGEAL STRICTURE</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/6</b> , 19 <b>78</b> , to <b>3/22</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>4/12</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Marci M. Menendez</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/22/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Marci M. Menendez</b>		22e. ADDRESS <b>5820 York Road Baltimore, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/26/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>		25a. DATE REC'D. BY REGISTRAR (b) REGISTRAR'S SIGNATURE <b>MAR 26 1985</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



EX-114 CAL 250017E

2/12/52 100-100000 11

091118

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM H ROBERTS			2a. DATE OF DEATH MONTH DAY YEAR MARCH 25, 1985			2b. HOUR P 6:17 M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 -6 30		6. AGE (IN YEARS (LAST BIRTHDAY)) 54 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 1725 Edmondson Avenue 21223							
14. FATHER'S NAME FIRST MIDDLE LAST Paul Martin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary L. Roberts			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-24-4386		17. INFORMANT ADDRESS William H. Roberts, Jr. 1 Kafern Drvie			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>poss. of pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic esophageal cancer</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 MIN 30 MIN 1 YEAR
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Depress</u>							
19a. DATE OF OPERATION 5 March 1985		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Calculation of esophagus		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>28 February 85</u> to <u>25 March 85</u> , that (I) (we) last saw the deceased alive on <u>25 March 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) saw the body after death.							
22b. SIGNATURE <u>Wm C March</u>				DEGREE MD		22c. DATE SIGNED 25 March 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm C March				22e. ADDRESS Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/30/85		23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR MAR 27 1985			
				25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

BP

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

08025

1. DECEASED NAME (TYPE OR PRINT) CARSON			MIDDLE ROBERTSON			LAST Sr.			2a. DATE OF DEATH MONTH DAY YEAR 3-8-85				2b. HOUR 3:35 PM				
3. SEX Male			4. RACE B			5. DATE OF BIRTH MONTH DAY YEAR 4-29-12			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.								
10. CITY OR TOWN OF DEATH Balto. City			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp. 2000 W Balto. St.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE Maryland						13b. COUNTY		13c. CITY OR TOWN Baltimore			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Robertson						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21225 603 Bridgeview Rd. Apt. E			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 225-01-1850			17. INFORMANT ADDRESS Apt. E Edna Robertson 603 Bridgeview Rd.											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 mins years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (b) <u>ESRD Impending gangrene of Right foot</u>																	
19a. DATE OF OPERATION 3/8/85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Impending gangrene of Right foot			19c. ALTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (GIVE NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION (STREET)			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/7, 1985 to 3/8, 1985, that (I) (we) lost saw the deceased alive on 3/8, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														22b. SIGNATURE [Signature] DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/14/85			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.			23d. LOCATION (CITY OR TOWN) Anne Arundel Co., Md.								
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR MAR 11 1985			25b. REGISTRAR'S SIGNATURE John Davidson-Randall								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

5 0 8 0 2 6

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <u>Baby (OG) Robinson</u>			2a DATE OF DEATH MONTH <u>3</u> DAY <u>11</u> YEAR <u>85</u>			2b HOUR <u>10:58</u> AM		
3 SEX <u>Female</u>		4 RACE <u>Black</u>		5 DATE OF BIRTH MONTH <u>2</u> DAY <u>16</u> YEAR <u>85</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>23</u> YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.		
10 CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Francis Skoy Med. Center</u>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>NA</u>		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a STATE <u>MD</u>		13b COUNTY <u>Balti</u>		13c CITY OR TOWN <u>Baltimore</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16 ADDRESS				
14 <u>NA</u>		15 <u>Nida Robinson</u>		16 <u>4440 Eastern Ave 21224</u>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b SOCIAL SECURITY NO. <u>NA</u>		17 INFORMANT ADDRESS				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Interventricular Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prematurity (Severe) 24-250 lbs Gestation</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cardiogenic Shock, Hyaline Membrane Dis- Breathing, Dis- Dis- Dis-</u>								
19a DATE OF OPERATION <u>P.D. AL Section 2/3/85</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, FURNISH MEDICAL EXAMINER) <u>NA</u>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>NA</u> <u>19</u>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>NA</u>				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO <input checked="" type="checkbox"/> WORK <u>NA</u>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) <u>NA</u>		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>2/16/85</u> to <u>3/11/85</u> , that (I) (we) lost saw the deceased alive on <u>3/11</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <u>Rudolph V Foy, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>3/11/85</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Rudolph V Foy, M.D.</u>		22e ADDRESS <u>4940 Eastern Ave, Balt., Md.</u>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b DATE <u>3/21/85</u>		23c NAME OF CEMETERY OR CREMATORY <u>By Hospital</u>		23d LOCATION CITY OR TOWN COUNTY STATE		
24 FUNERAL DIRECTOR NAME <u>Anatomy Board</u>				ADDRESS <u>Balto., Md.</u>		25a DATE REC'D. BY REGISTRAR <u>MAR 26 1985</u>		
				25b REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



08-11-11

11-11-11



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08027  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				2b. DATE OF DEATH				2c. DATE OF DEATH				2d. DATE OF DEATH			
ERICA DANELL COLE ROBINSON				3 23 85				3 23 85				3 23 85				3:57A			
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY OR COUNTY OF DEATH		11. BALTIMORE CITY OR COUNTY OF DEATH			
FEMALE		BLACK		11 02 84		YRS. 4		MONTHS		DAYS		Baltimore City, MD.		Baltimore City, MD.		Baltimore City, MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				10. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland				U. S. A.								Baltimore City, MD.				Baltimore City, MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				13. BALTIMORE CITY OR COUNTY OF DEATH			
Baltimore				Provident Hospital				None				None				Baltimore City, MD.			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Maryland								Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				3028 W. North Avenue Baltimore, Maryland 21216			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT			
Eugene C. Cole, Jr.				Robin J. Robinson				No.				219-06-7678				Edde V. Wright			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I DEATH WAS CAUSED BY:				IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u>				DUE TO, OR AS A CONSEQUENCE OF				DUE TO, OR AS A CONSEQUENCE OF				DUE TO, OR AS A CONSEQUENCE OF			
7980				Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED				3/23/85							
EXAMINER'S NAME (TYPE OR PRINT)				M.D. Assistant				MEDICAL EXAMINER											
Gregory R. Kauffman, M.D.				111 Penn St. Balto., Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE				23e. DATE REC'D. BY REGISTRAR			
Burial				3/27/1985				Cedar Hill Cemetery				Baltimore, Maryland				MAR 27 1985			
24. FUNERAL DIRECTOR NAME				25. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Nutter & Sons				2501 Gwynns Falls Parkway				Funeral Home, Inc. ■ Baltimore, Maryland 21216											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DHMH - 17  
(VR A15 ME (5))

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2-11-1961, Monday

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Francine T. Robinson			2a. DATE OF DEATH MONTH DAY YEAR 3-9-85			2b. HOUR M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5-31-26		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 145 N. Edgewood St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING TIME) Private fam.	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Savage		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Savage					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 217-20-1846		17. INFORMANT ADDRESS Andrew Robinson 145 Edgewood St (29)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma to Lungs +</u> DUE TO, OR AS A CONSEQUENCE OF <u>Chest wall.</u> (b) <u>Bilateral Breast-Cancers-</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>E. J. Rice</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-11-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chas. A. Rice				22e. ADDRESS FSPA 1300 Eutaw Place			
23a. BURIAL, CREMATION, REMOVAL (SEE CR)		23b. DATE 3-14-85		23c. NAME OF CEMETERY OR CREMATORY Loudon Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Chas. A. Rice				25. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE MAR 15 1985			

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MEDICAL CERTIFICATION

— 17 —

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

08029

FOR  
1 - STATE  
REGISTRAR

091135

1. DECEASED NAME (TYPE OR PRINT) Henry Robinson		2a. DATE OF DEATH MONTH DAY YEAR 3 20 85		2b. HOUR 11:21 PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 6 13 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROPRIETOR	12b. KIND OF BUSINESS OR INDUSTRY FURNITURE STORE
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY BALTO.	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX
14. FATHER'S NAME FIRST MIDDLE LAST EMANUEL ROBINSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE KAHN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO.		
17. INFORMANT MRS. MILDRED ROBINSON		3401 OLD FOREST RD. BALTO., MD 21208		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CONGESTIVE HEART FAILURE.

DUE TO, OR AS A CONSEQUENCE OF

(b)

ASCVD

DUE TO, OR AS A CONSEQUENCE OF

(c)

ATRIA FIBRILLATION

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

9a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/15, 19 85, to 3/20, 19 85, that (I) (we) last saw the deceased alive on 3/20, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If death did not occur, the body after death.)			
22b. SIGNATURE Clifford L. Amend	DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 3/20/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clifford L. Amend	22e. ADDRESS Sinai Hospital		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MAR. 22, 1985	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR MAR 27 1985	25b. REGISTRAR'S SIGNATURE Williamson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner or coroner must be notified.

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0975615  
BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
1- FOR STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) JOSEPH S. ROBINSON, JR.						2a DATE OF DEATH MONTH DAY YEAR MARCH 19 1985		2b HOUR 9:36A <sup>M</sup>			
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 23 21		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY 13c. CITY OR TOWN Baltimore						13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4212 Colborne Rd. 21229			
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Robinson				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Finch							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 246-18-2594		17. INFORMANT ADDRESS Lula N. Robinson 4212 Colborne Rd.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured Thoracic Aortic Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) Uncontrolled Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs 12 hrs Several years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal Failure											
19a DATE OF OPERATION 3/18/85		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Thoracic Aortic Aneurysm				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/18/85 to 3-19-85 that (I) (we) last saw the deceased alive on 3-19-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William C Dooley MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/19/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William C Dooley				22e. ADDRESS Johns Hopkins Hospital							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/22/85		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills MD					
24 FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.				25. RECORDED BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST (18022) Leolia Justine Robinson					20. DATE OF DEATH MONTH DAY YEAR 3 14 85			2b HOUR 12 <sup>35</sup> PM				
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 2 11 19		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN md. Baltimore Baltimore					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1502 PENNSYLVANIA AVE 21217					
14. FATHER'S NAME FIRST MIDDLE LAST Royal Spriggs					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 220.01.0437		17. INFORMANT ADDRESS Vivian B. Davidson 4518 Umatilla Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SUBARACHNOID HEMORRHAGE 8 days DUE TO, OR AS A CONSEQUENCE OF (c)										INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3-6, 19 85, to 3-14, 19 85, that (I) (we) last saw the deceased alive on 3-14, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Louis Solomon MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/14/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Solomon					22e. ADDRESS University Hospital							
23a. BURIAL, CREMATION, REMOVAL (TYPE)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			3/20/85		Arbutus Mem. Pk			Balto. Md.				
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE MAR 19 1985					

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

081373

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WALTON C. ROBINSON, JR.					2a. DATE OF DEATH MONTH DAY YEAR 03/01/85			2b. HOUR 1:50A M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 29 08		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mould Maker		12b. KIND OF BUSINESS OR INDUSTRY Glass Industry			
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore Highlands		13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Walton C. Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Marts						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-01-4694		17. INFORMANT ADDRESS Walt Robinson 706 Dorchester Rd. 21229							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF c) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4/4/72, 19 to 3/01, 1985, that (I) (we) last saw the deceased alive on 2/9/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.											
22b. SIGNATURE E. KASATIS, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 03/01/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. KASATIS, M.D.					22e. ADDRESS 1801 FREDERICK RD BALTIMORE, MD 21228						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/4/85		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.					24b. ADDRESS 21229		24c. DATE REC'D. BY REGISTRAR MAR 4 1985		24d. REGISTRAR'S SIGNATURE W. Davidson-Randall		

MEDICAL CERTIFICATION

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST BARBARA	MIDDLE Wheeler	LAST ROCK	2a. DATE OF DEATH MONTH DAY YEAR MARCH 28, 1985		2b. HOUR P 1:10 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 5 7 37		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Med. Lab Tech.		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. CITY OR TOWN Columbia		13c. STREET ADDRESS / ZIP CODE 11127 Willowbottom Dr. 21044		
14. FATHER'S NAME FIRST MIDDLE LAST Omer W. Wheeler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maureen C. Perrizo				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 658-46-9791		17. INFORMANT ADDRESS Robert C. Rock 11127 Willowbottom Dr. Columbia, Md. 21044				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aplasia secondary to myeloid leukemia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>1 day</u> <u>1 1/2 years</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <u>3-20</u> , 19 <u>85</u> , to <u>3-28</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3-28</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)								
22b. SIGNATURE <u>William M. Russell</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>3-28-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William M. Russell</u>				22e. ADDRESS <u>Hopkins Hosp.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>3-29-85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Security Process</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto.</u> <u>Md.</u>		
24. FUNERAL DIRECTOR NAME <u>MacNabb F.H. Catonsville, Md. 21228</u>				25a. DATE REC'D. BY REGISTRAR <u>APR 1 - 1985</u>		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edward Rock</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>3 11 85</b>					2b. HOUR M <b>AM</b>	
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 1 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	
2a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		2b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balt.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md</b>		13b. COUNTY <b>Balt</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1630 Poplar Grove St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Rock</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mazzie Winder</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW 16</b>		12. INFORMANT <b>Louise Rock</b>				ADDRESS <b>Baltimore Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiomyopathy, Cardiac Arrhythmia</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Soft 77 March 19 85</b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>March 19 85</b> to <b>March 19 85</b> , that (I) (we) last saw the deceased alive on <b>3/11/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Marshall A. Levine MD</b>					DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/18/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marshall A. Levine</b>					22e. ADDRESS <b>711 W. 40th St. Baltimore, MD, 21211</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/16/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grace U.M. Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Venton Som Md</b>			
24. FUNERAL DIRECTOR NAME <b>Anthony E. Howard Crispfield, MD.</b>					ADDRESS <b>MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rodgers</b>		

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(VRA 15, 4)

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>George</i>		MIDDLE		LAST <i>Rodenberg</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>March 29, 1985</i>		2b. HOUR <i>7 A.M.</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 4 20</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) <i>5514 Lyndale Avenue 21213</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Painter</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE <i>829 South Oldham St. 21224</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY -----		13c. CITY OR TOWN <i>Baltimore</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Rodenberg</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Frances Dahms</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>217-12-9579</i>		17. INFORMANT ADDRESS <i>Rose Burke 45 Trudy Dr. Sykesville 21784</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Ca lung (RT) Metastasis (widely spread)</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4.1.85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>TARIQUE FIROUZI</i>						22e. ADDRESS <i>223 EASTERN BLVD. 21221</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>4-1-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Eastwood Balto. Co. Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave.</i>						25. PREPARED BY NAME ADDRESS <i>[Signature]</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 8 0 3 6

1. DECEASED NAME (TYPE OR PRINT) Melvin Ernest Rodgers			20. DATE OF DEATH MONTH DAY YEAR 3/21/85			2b. HOUR 4:30 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 29 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2942 Keswick Road 21211	
14. FATHER'S NAME FIRST MIDDLE LAST Henry R. Rodgers			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Milton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS Neila Parrish 933 Lance Avenue 21221					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>C.H.F., Arteriosclerosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/18</u> 19 <u>85</u> to <u>3/21</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/21</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Paul F. Stearns</u> MD				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. ANK STROMBERG				22e. ADDRESS Union Memorial Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/23/85		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. 3615-19 Chestnut Ave.				ADDRESS 21211		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 26 1985 Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

SECRET  
NO FORN DISSEM

SECRET

CO-ORDINATION

FILED IN

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, for any injury, or other traumatic event, the medical examiner must be contacted.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM HARRY ROGERS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 8, 1985</b>			2b. HOUR <b>9:04 p</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 16 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHURCH HOME HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sup. of Quality Control</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Glen L. Martin</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5817 Ebenezer Rd. 21162</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Bertrand</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Maude Tydemann</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>139-05-1250</b>		17. INFORMANT ADDRESS <b>Richard M. Rogers 5910 Ebenezer Rd. 21162</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PERFORATED DUODENAL ULCER</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE EXACERBATION OF C.O.P.D.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>9</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>FEBRUARY 27, 1985</b> to <b>MARCH 8, 1985</b> , that (I) (we) last saw the deceased alive on <b>MARCH 8, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not have any body or body part removed.									
22b. SIGNATURE <b>H. Bijpuria</b>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		DATE SIGNED <b>MARCH 8, 1985</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MURARI BIJPURIA</b>				22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION &amp; 100 NORTH BROADWAY BALTIMORE, MD 21233</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-12-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Harford Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>MARCH 13 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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9-24-17 10:11:00 AM

NOT A PARTIAL



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CLARENCE W. ROSS			2a. DATE OF DEATH MONTH DAY YEAR MARCH 22 1985			2b. HOUR 4:15 A.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 4 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 123 S. BOULDIN ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY POST OFFICE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 123 S. BOULDIN ST. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM ROSS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 212-22-9287		17. INFORMANT ADDRESS GRACE ROSS (WIFE) SAME ADDRESS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Lung Cancer

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 years

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/6 19 85, to 3/22 19 85, that (I) (we) last saw the deceased alive on 3/19 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Dennis MacDonald				DEGREE MD		22c. DATE SIGNED 3/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Dennis MacDonald				22e. ADDRESS 9 S. Highland Ave.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/25/85		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane Balto. Md. 21218				25. DATE REC'D. BY REGISTRAR MAR 22 1985		25b. REGISTRAR'S SIGNATURE W. Harrison-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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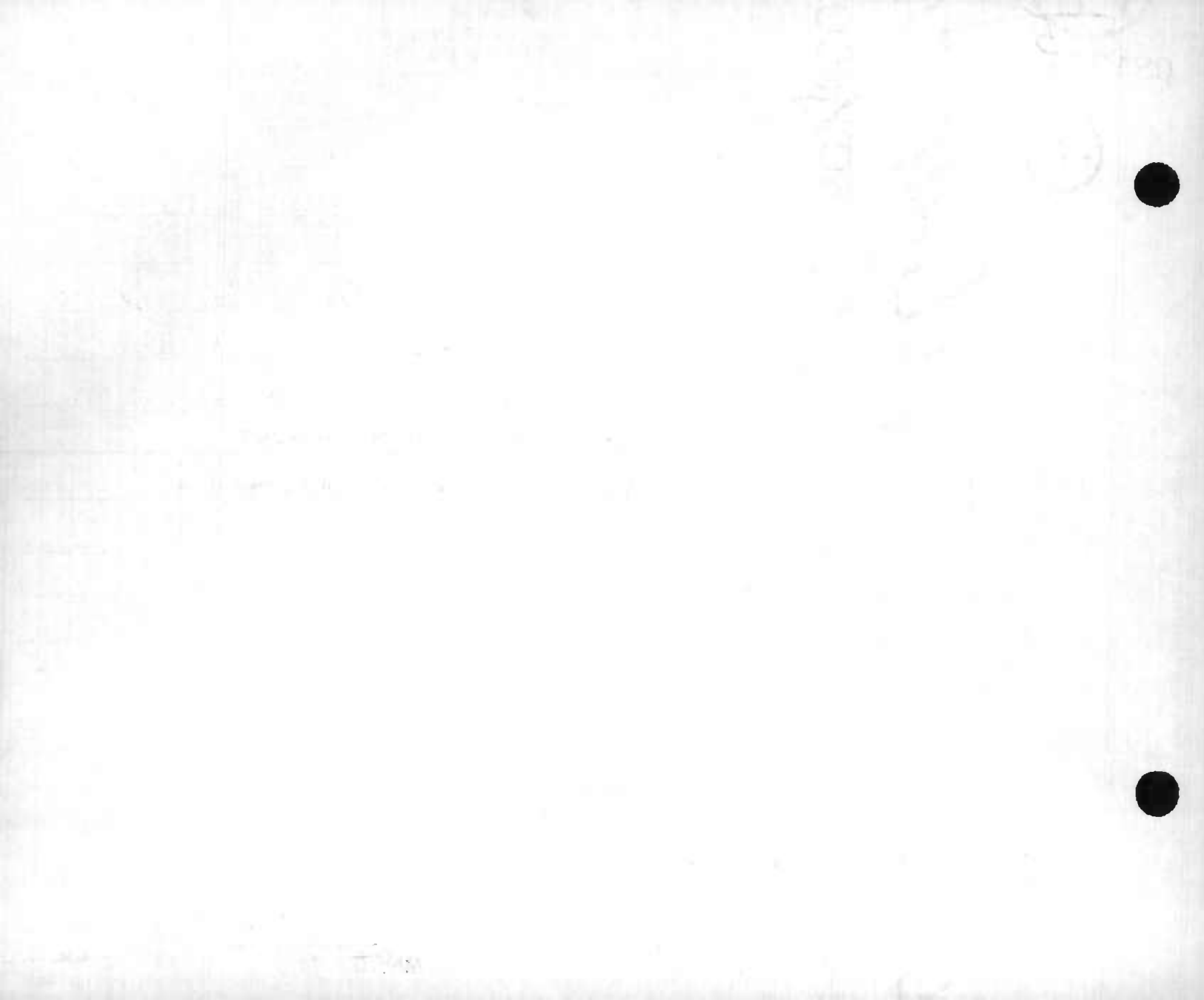
081374

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grady Ross			2a. DATE OF DEATH MONTH DAY YEAR 3 2 1985			2b. HOUR M					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 19 10		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ark.		7b. CITIZEN OF WHAT COUNTRY? Usa		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2603 Maisbury Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2603 Maisbury Ct. 21230			
14. FATHER'S NAME FIRST MIDDLE LAST George Ross				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Hicks							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 429-16-9148		17. INFORMANT ADDRESS Mildred Mitchell 546 Orchard St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD CARDIAC ARRHYTHMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>COPD</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE D. Shamsuddin						DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. SHAMSUDDIN						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/8/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. MD			
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave						25a. DATE REC'D. BY REGISTRAR MAR 5 1985			25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 08040

REG. NO.

FOR 1 - STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) <i>Hilda ROUSER</i>		DATE OF DEATH MONTH DAY YEAR <i>3 17 85</i>		TIME OF DEATH HOUR MIN <i>7:20 AM</i>	
1 SEX <i>F</i>		4 RACE <i>Black</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>6 - 26 - 1920</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>64</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City MD</i>	
10 CITY OR TOWN OF DEATH <i>Baltimore</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY <i>School System</i>	
13a RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Md.</i>		13b COUNTY <i>Balto.</i>		13c CITY OR TOWN <i>Balto.</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>William Rouser</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lena Rouser</i>		16 STREET ADDRESS / ZIP CODE <i>709 Portland Stt 21230</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. <i>216-16-8990</i>		17 INFORMANT ADDRESS <i>Lena Rouser 709 Portland St. 21230</i>			

II. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Metastatic Oat Cell CA*

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

18a. DATE OF OPERATION		18b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22c. LOCATION STREET CITY OR TOWN COUNTY STATE			

I certify that (I) (this hospital) attended the deceased from *2/21* 19 *85* to *3/17* 19 *85*, that (I) (we) last saw the deceased alive on *3/17* 19 *85*, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED <i>3/17/85</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dorian St Martin</i>		22e ADDRESS <i>Mercy Hosp</i>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>3-21-85</i>		23c NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Pk.</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Arbutus Prince Georges</i>	
24 FUNERAL DIRECTOR NAME ADDRESS <i>Chas.A.Rice FSPA 1300 Eutaw Place</i>				25a DATE REC'D BY REGISTRAR <i>MAR 20 1985</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

08041

1- FOR  
STATE  
REGISTRAR

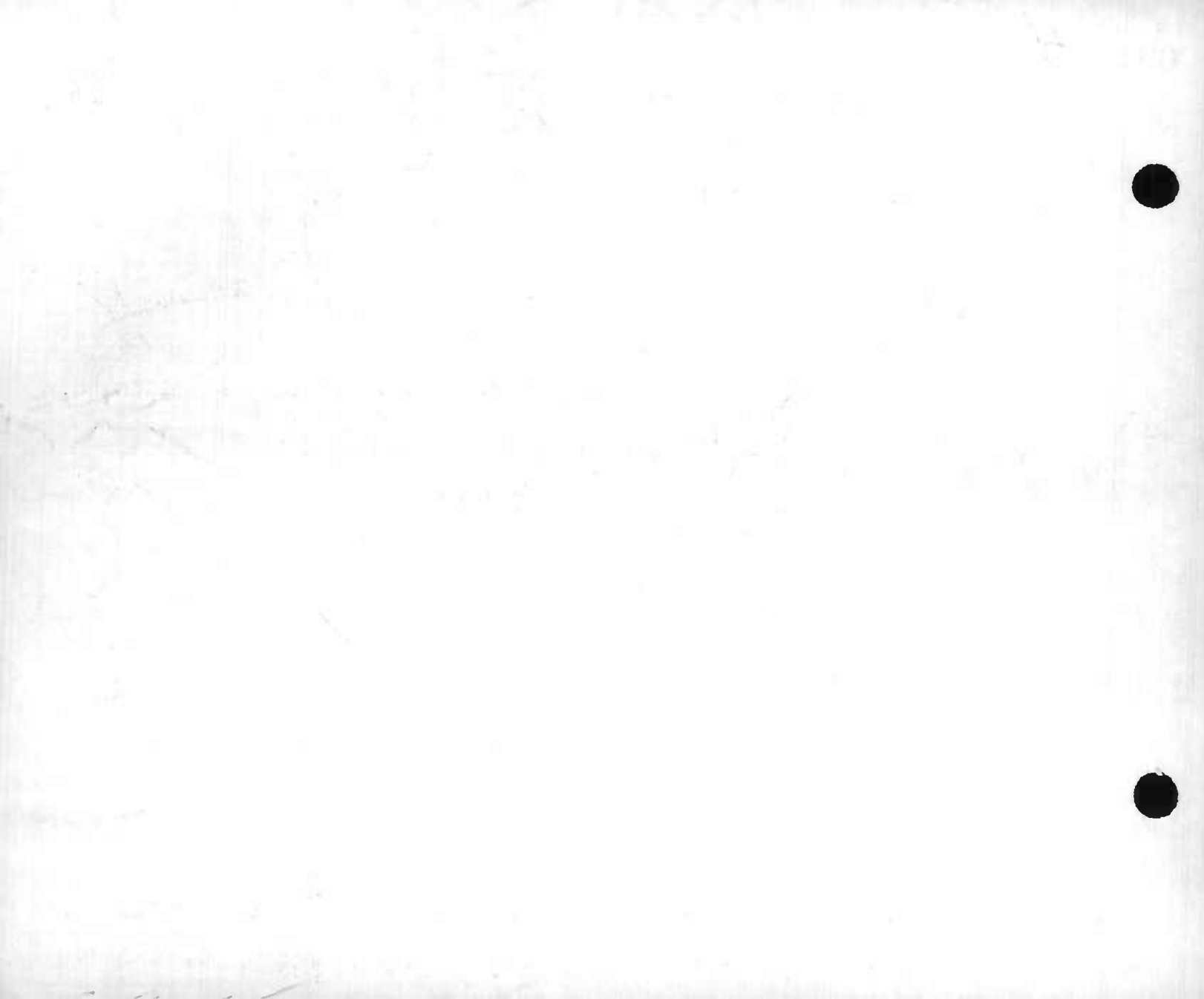
1. DECEASED NAME (TYPE OR PRINT) <u>Geralean C. Royal</u> <u>Gervalean</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>3 / 25 / 85</u>			2b. HOUR <u>4<sup>35</sup> AM</u>				
3. SEX <u>♀ Female</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>5 7 25</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>59</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) <u>Balto.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>City</u> MD.				
10. CITY OR TOWN OF DEATH <u>Balt</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sinai</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Porter</u>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>MD</u>			13b. COUNTY <u>Balt</u>		13c. CITY OR TOWN <u>Balt</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>3925 Annellen Rd</u> 21215	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Joseph Dorsey</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary Smothers</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO. <u>220-20-4764</u>		17. INFORMANT ADDRESS <u>Frank C. Royal 3925 Annellen Rd.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>renal failure / uremia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>several years</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/11/85</u> , 19 <u>85</u> , to <u>3/25</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/25</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Steven Lerman</u>					DEGREE		22c. DATE SIGNED <u>3/25/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Steven Lerman</u>					22e. ADDRESS <u>Sinai Hosp Balt MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>3/29/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Garrison Forest V/A</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Owings Mills Md.</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>Wm. C. March F/H 1101 E. North Ave.</u>					25a. DATE REC'D. BY REGISTRAR <u>MAR 26 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

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9

BP



087049

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 0 4 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES F. RUFF</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 21 85</b>		2b. HOUR <b>150 PM</b>
3. SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 5 08</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Arbutus</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Christopher Ruff</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Steinwedel</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>555-01-8433</b>		17 INFORMANT ADDRESS <b>Charlotte A. Ruff 1218 Elmridge Ave. 21229</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intercerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.B. - kidney with metastasis to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>the lungs</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>NO</u>					
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-13</u> 19 <u>85</u> to <u>3-21</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3-21</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>R. Williams</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3-21-85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RENNER WILLIAMS</b>		22e. ADDRESS <b>S.A.H.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/25/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>		ADDRESS <b>4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>3-27-85</b>	25b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

087043





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

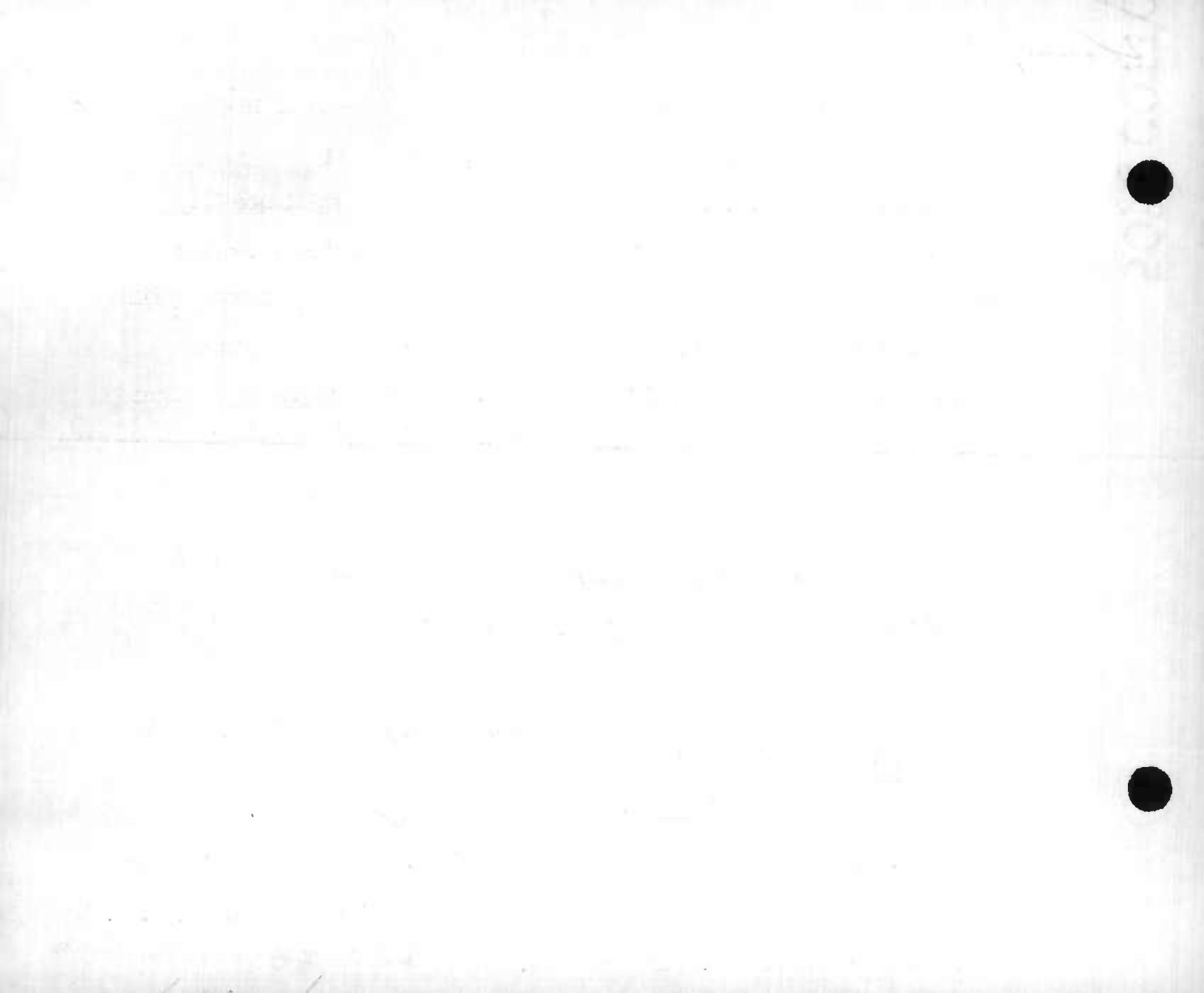
1. DECEASED NAME (TYPE OR PRINT) Ance Runyon			2a. DATE OF DEATH MONTH DAY YEAR March 2, 1985		2b. HOUR 8 A M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 23, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
13. CITY OR TOWN OF DEATH Baltimore		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3604 Elm Avenue				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Worker			16. KIND OF BUSINESS OR INDUSTRY		
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Maryland		18. COUNTY Baltimore		19. CITY OR TOWN Baltimore		20. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. STREET ADDRESS / ZIP CODE 3604 Elm Avenue 21211			
22. FATHER'S NAME FIRST MIDDLE LAST Halford Runyon				23. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Evans							
24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				25. SOCIAL SECURITY NO. 233 22 5280		26. INFORMANT Mrs. Katherine Runyon				27. ADDRESS Same	
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROGRESSIVE COLON CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>CHRONIC UPPER ABD. INFECTION</u>											
29a. DATE OF OPERATION 8/12/84		29b. CONDITION FOR WHICH OPERATION WAS PERFORMED Recurrent Colon Cancer				30a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		30b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
31a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		31b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		31c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
32a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		32b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		32c. LOCATION STREET CITY OR TOWN COUNTY STATE 819 St 8/102 84							
33. I certify that (I) (this hospital) attended the deceased from <u>8/12/84</u> 19 <u>84</u> to <u>8/102</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on above (Date) (did) (did not) view the body after death.											
34. SIGNATURE <u>Dr. Elliott Badder</u>				35. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				36. DATE SIGNED			
37. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Elliott Badder				38. ADDRESS 301 St. Paul Place Baltimore							
39. BURIAL, CREMATION, REMOVAL Burial		40. DATE 03/05/1985		41. NAME OF CEMETERY OR CREMATORY Mays Chapel Cemetery		42. LOCATION CITY OR TOWN COUNTY STATE Lutherville, Balto.CO. MD					
43. FUNERAL DIRECTOR NAME ADDRESS Burgee-Henss Funeral Home 3631 Falls Rd. 21211				44. DATE REC'D. BY REGISTRAR MAR 6 1985		45. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.



086059

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

08044

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES R. RUSSELL</b>			2a DATE OF DEATH MONTH DAY YEAR <b>March 22, 1985</b>		2b HOUR <b>2:14 AM</b>								
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>11 23 1902</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8 IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.							
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POLICE OFFICER</b>		12b KIND OF BUSINESS OR INDUSTRY CITY OF <b>BALTIMORE</b>					
13a STATE <b>MARYLAND</b>						13b COUNTY <b>---</b>		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>4907 PARKTON COURT, 21229</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b SOCIAL SECURITY NO <b>212-26-3286</b>		17 INFORMANT ADDRESS <b>MARY MARGARET RUSSELL 4907 PARKTON COURT 21229</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>sepsis, alcoholic cirrhosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>year</u>			
19a DATE OF OPERATION <u>March 11, 1985</u>				19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>sepsis, alcoholic cirrhosis</u>				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>March 11, 1985</u> to <u>March 22, 1985</u> , that (I) (we) last saw the deceased alive on <u>March 22, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <u>Russell J. Stankiewicz</u>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <u>3/22/85</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Russell J. Stankiewicz</u>						22e ADDRESS <u>ST. AGNES HOSPITAL, 900 S. CATON AVE.</u>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b DATE <b>03-25-85</b>		23c NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>WOODLAWN BALTIMORE MARYLAND</b>					
24 FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>						24b ADDRESS <b>4107 WILKENS AVE.</b>		25a DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>		25b REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

020320

20% COTTON YARN

WATER



18  
098080STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8045

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Ellen S Russell</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>03-30-85</b>		2b. HOUR M <b>AM</b>	
3. SEX <b>female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-23--11</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		8. IF UNDER 1 YEAR MONTHS DAYS <b>73</b>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.		10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3211 POWHATTAN AVE. 21216</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS <b>3211 POWHATTAN AVE. 21216</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES S. SCOTT</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DELLA PINKNEY</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>D</b>	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>WILLIAM RUSSELL 3211 POWHATTAN AVE. 21216</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sugar Nucleus Ophthalmoplegia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Malnutrition</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9/6 19 51</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>3/24</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>114 Medical Arts Bldg</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/24</b> 19 <b>51</b> , to <b>3/30</b> 19 <b>51</b> , that (I) (we) last saw the deceased alive on <b>3/24</b> 19 <b>51</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) sign the body after death.					
22b. SIGNATURE <b>Robert J. Gery</b>		DEGREE <b>M</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>APR 2 1985</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert J. Gery</b>		22e. ADDRESS <b>114 Medical Arts Bldg</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4-3-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>E.L. PHILLIPS 1721 N. MONROE ST.</b>			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

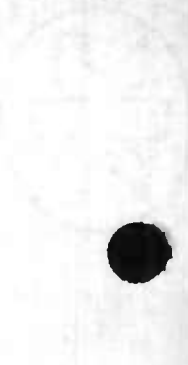
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2408

STATE OF TEXAS  
COUNTY OF DALLAS  
CERTIFICATE OF MARRIAGE

9  
03800



Witness my hand and seal this 15th day of May 1908.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 0 4 6

1 - FOR  
STATE  
REGISTRAR MATTHEW J. RUSSELL

REG. NO.

085128

DECEASED NAME (TYPE OR PRINT) MATTHEW J. Russell			2a. DATE OF DEATH MONTH DAY YEAR 3 20 85		2b. HOUR 7:30 AM	
3 SEX MALE	4 RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 01 14 67		6 AGE (IN YEARS LAST BIRTHDAY) 18 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY of MARYLAND		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT.		12b. KIND OF BUSINESS OR INDUSTRY High School	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE M.D.			13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1233 ALEXANDER AVE 21228			
14 FATHER'S NAME FIRST MIDDLE LAST James D. Russell			15 MOTHER'S MAIDEN NAME FIRST MIDDLE Mary Alexander			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-88-3622		17 INFORMANT James D. Russell St. Petersburg, Fla. 33710	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

8199

IMMEDIATE CAUSE (a) RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(b) PULMONARY CONTUSION

DUE TO, OR AS A CONSEQUENCE OF

(c) MOTOR VEHICLE ACCIDENT

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

26 days

26 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MULTIPLE ORGAN FAILURE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> (OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER))	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 2 25 1985	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) MOTOR VEHICLE ACCIDENT	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) STREET	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 02/25/85 to 3/20/85, that (I) (we) lost saw the deceased alive on 3/20 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE C. Russell		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/20/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James C. Russell		22e. ADDRESS Baltimore, md. UNIVERSITY of MARYLAND/MEIMS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/23/85	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Md.
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228		25a. DATE REC'D. BY REGISTRAR MAR 21 1985	

082138



RECEIVED



081376

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Albert JOSEPH Saboury SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 08 85</b>		2b. HOUR <b>11000</b> M
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 15 88</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS.	
7a. BIRTHPLACE (COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALT CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED MECH.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AUTOMOBILE</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>ANNE ARUNDEL</b>	13c. CITY OR TOWN <b>CLIN DORVILLE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>U/K</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>U/K</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218014786</b>		17. INFORMANT ADDRESS <b>DE PREE 3001 S. HANOVER BALT MD</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiopulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

**Small + large bowel obstruction**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/2/85</b> , 19____, to <b>3/8/85</b> , 19____, that (I) (we) lost saw the deceased <del>alive on</del> above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>D. DePree</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>3/8/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. DePree</b>		22e. ADDRESS <b>3001 HANOVER BALT. MD 21230</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>3-11-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALDWIN MEM. CEMETERY</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>MILLERSVILLE ANNE ARUNDEL MD.</b>
24. FUNERAL DIRECTOR NAME <b>McGully FUNERAL HOME OF PASADENA</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1985</b>	25b. REGISTRAR'S SIGNATURE <b>William Randall</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



086101

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

08048

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
Conrad						Sadler		3/ 25/ 85								M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male		Cauc.		3 30 1931		63 YRS.				3/25/ 1985						M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										MD.	
North Carolina		U.S.A.				Baltimore City											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		225 N. Lakewood Ave.		Fork Lift Driver		Automotive											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Md.				Baltimore				225 N. Lakewood Ave.								21224	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
Samuel		Matty		243-16-8047		Barbara Sadler		225 N. Lakewood Ave.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)															
No																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 3/26/85									
ACTUAL SIGNATURE		EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS													
Gregory R. Kauffman, M.D.		111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		3/28/85		Hopewell Cemetery		Port Deposit Cecil Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
B. Dabrowski & Son		2818 E. Baltimore St.		MAR 26 1985		G. Anderson-Randall											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Viola I. SADLER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 19, 1985</b>			2b. HOUR <b>3:15P<sup>M</sup></b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 18 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital 21201</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13e. STREET ADDRESS / ZIP CODE <b>1600 W. Mt. Royal Ave. 21217</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Jeffries</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose (unknown)</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT ADDRESS <b>Eleanor Sadler Hitt 1600 W. Mt. Royal Ave. 21217</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (x) (this hospital) attended the deceased from <b>March 19</b> , 19 <b>85</b> , to <b>March 19</b> , 19 <b>85</b> , that (x) (we) lost saw the deceased alive on <b>March 19</b> , 19 <b>85</b> , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above (x) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Shoaib Hashmi</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3/19/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Shoaib Hashmi, M.D.</b>					22e. ADDRESS <b>c/o Maryland General Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/23/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem. (Hamden)</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>A. Alan Seitz Funeral Home</b>					24b. ADDRESS <b>3818 Roland Ave.</b>		25. DATE OF DEATH <b>MAR 26 1985</b>		

MEDICAL CERTIFICATION

29

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILTON J. SALTER		2a. DATE OF DEATH MONTH DAY YEAR 3-12-85		2b. HOUR 3:50 M	
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 07 13 42		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 242-62-7681		17. INFORMANT Dorothy A. Sadler 2702 Harlem Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/20 19 85, to 3/12 19 85, that (I) (we) last saw the deceased alive on 3/12 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE BUI T DUONG		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BUI T DUONG		22e. ADDRESS LUTHERAN HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 3/16/85		23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk.	
23d. LOCATION BALTIMORE, MD.		23e. COUNTY			
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR MAR 14 1985		25b. REGISTRAR'S SIGNATURE P. K. J. ...	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 410-325-3000.







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 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

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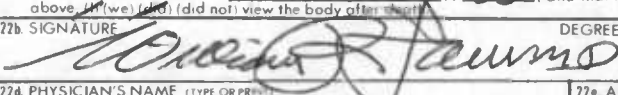
1- FOR  
STATE  
REGISTRAR

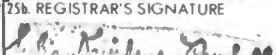
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN SAMUELS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 25 85</b>		2b. HOUR MIN. <b>4 22 AM</b>		
3. SEX <b>MALE</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 21 32</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>52</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>604 N. Fulton Ave. (Home)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE <b>Md.</b>	13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>LeRoy Carter</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clora Stovall</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216 288183</b>	
17. INFORMANT ADDRESS <b>Lola Samuels 604 N. Fulton Ave. (17)</b>			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MIN</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Occlusion</b>		<b>MIN</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Syndrome</b>		<b>YRS</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>Aortic Valve Replacement Mar 85; Congestive Heart Failure</b>			
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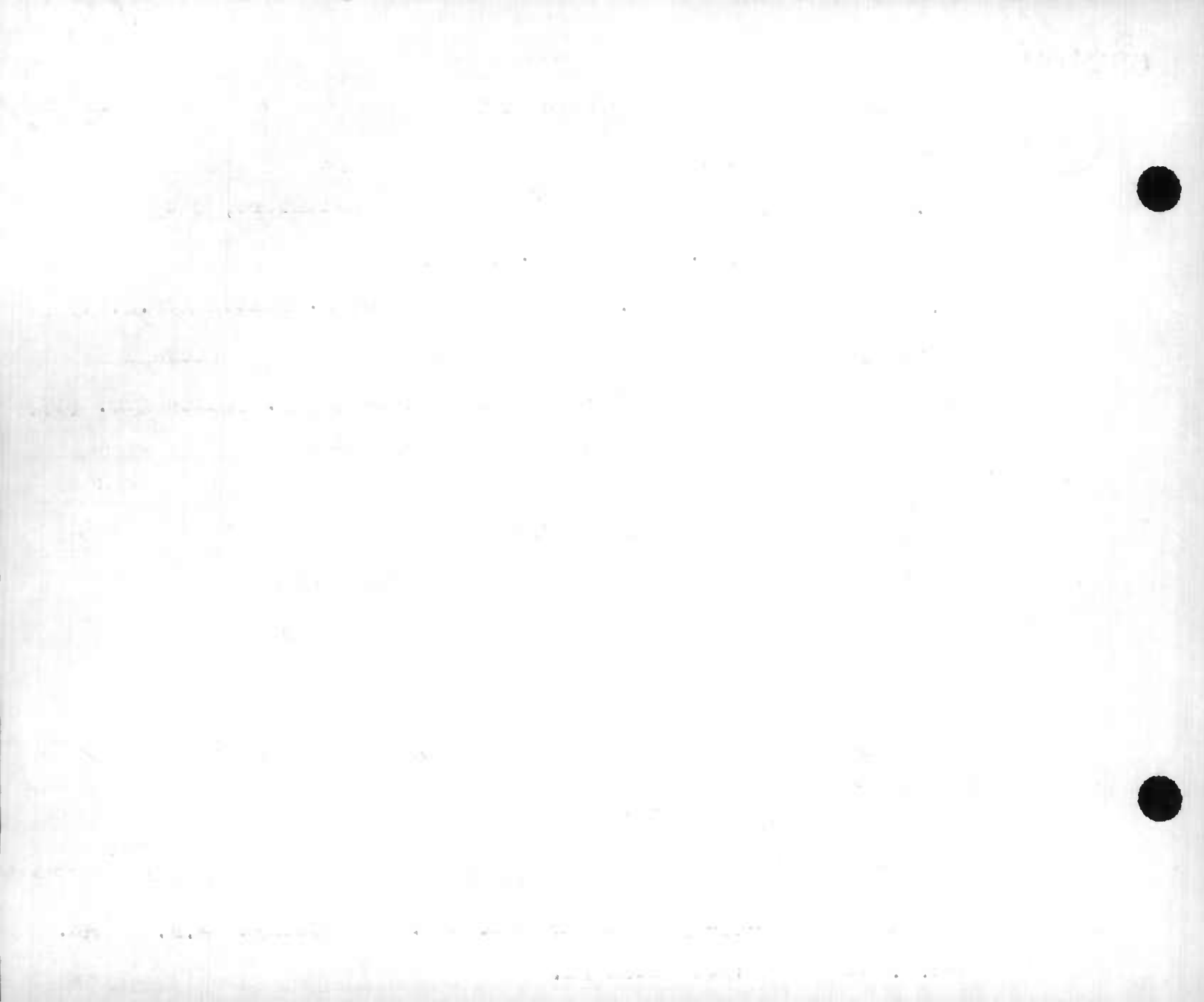
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>19 67</b> to <b>present</b> 19 <b>85</b> , that (we) last saw the deceased alive on <b>3-22</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death)							
22b. SIGNATURE 		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM R. LAW M.D.</b>		22e. ADDRESS <b>BOW SECOURS HOSPITAL</b> <b>2000 W. BALTIMORE ST BALTO. MD 21223</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-29-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn A.A. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Chas. A. Rice FSPA 1300 Eutaw Pl.</b>				25a. DATE REC'D BY REGISTRAR <b>MAR 29 1985</b>			
25b. REGISTRAR'S SIGNATURE 							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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FOR 5/14/85 rja  
STATE REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NINA ADELINE SANCHUK			2a. DATE OF DEATH MONTH DAY YEAR 3 18 85			2b. HOUR 8:30P M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 03 22 1895		6. AGE (IN YEARS LAST BIRTHDAY) 88-89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN ROSEDALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8215 PHILADELPHIA RD 21237	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT --- SHORES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA --- BAKER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS RUTH HAUSER 8215 PHILADELPHIA RD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>887 CVA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Essential Hypertension, Angina syndrome</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) attended the deceased from <u>9-25-76</u> , 19____, to <u>3-18-85</u> , 19____, that (I) (we) last saw the deceased alive on <u>3-2-85</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Everett Sutter M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-21-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Everett Sutter M.D.				22e. ADDRESS P.O. Box 100 Dames Quarter Md. 21220					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/22/85		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO --- MD		23e. DATE REC'D. BY REGISTRAR MAR 26 1985	
24. FUNERAL DIRECTOR NAME <u>1211 Chesapeake Ave.</u>				25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Robert SANDERS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 17 85</b>			2b. HOUR <b>8:40 a.m.</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 18 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>				12a. USUAL OCCUPATION (IF WORK FOR LOSS OF WORKING LIFE) <b>Truck Driver</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. STREET ADDRESS / ZIP CODE <b>1612 Clifton Ave. 21217</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Molton Sanders</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lend Danzy</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>239-4827-65</b>		17. INFORMANT ADDRESS <b>Frank Sanders 1715 Westwood Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>DIABETES</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/7/85</b> 19 <b>85</b> , to <b>3-17</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3-16</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Eric Bunning MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-17-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/18/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem Ph.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Bailey-Douglass</b>				ADDRESS <b>1348 Calhoun St</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1985</b>	
				25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

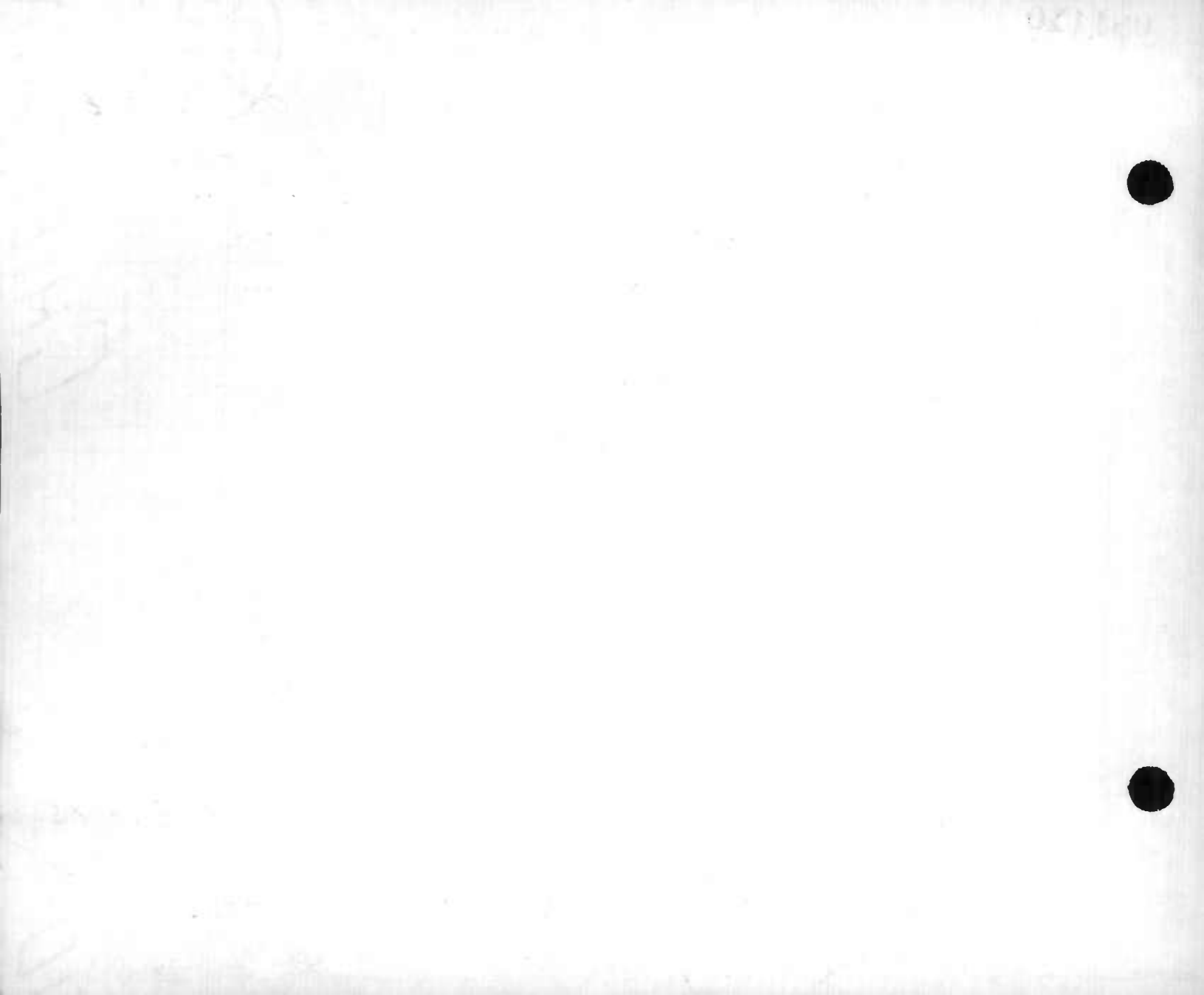
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



086007

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 0 5 4

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BYRON SASSER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 17, 1985</b>			2b. HOUR <b>11:20p</b>				
3. SEX <b>M</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-30-1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DISABLED</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>BALTO.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>814 S. ROSE ST. 21224</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>RONNIE SASSER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LULA BYRD</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>212-30-1416</b>		17. INFORMANT ADDRESS <b>EVA M. SASSEK SAME AS 13E.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatocellular syndrome</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Portal Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cirrhosis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 years</b> <b>16 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Infectious disease</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/23/85</b> , 19 <b>85</b> , to <b>3/17</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/17</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Michele F. Nowotarski</b>					DEGREE <b>MD</b>		22c. DATE SIGNED <b>3-17-85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michele F. Nowotarski</b>					22e. ADDRESS <b>600 N. WOLFE ST. BALTIMORE, MD 21205</b>					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>BURIAL</b>			23b. DATE <b>3-21-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OKLAHOMA CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY <b>BALTO. CO. MD.</b>			
24. FUNERAL DIRECTOR NAME <b>THOMAS J. SKARDA 2829 HUDSON ST.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1985</b>		25b. REGISTRAR'S SIGNATURE <b>J. Davidson</b>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

*[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALBERT E Satterfield			2a. DATE OF DEATH MONTH DAY YEAR March 20 85			2b. HOUR 10 <sup>22</sup> PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 23 23		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) J.L. Peaton Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipfitter		12b. KIND OF BUSINESS OR INDUSTRY Steel	
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN State		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Peter Satterfield			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geraldine Cole			13e. STREET ADDRESS / ZIP CODE 3905 Orleans St. 21224			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-18-0893		17. INFORMANT ADDRESS P.O. Box 6139 Mr. Peter Satterfield Balto., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE 2° to Hypercalcemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 28</u> 19 <u>85</u> to <u>MARCH 20</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>MARCH 20</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did/did not) view the body after death.									
22b. SIGNATURE <u>George J. Rodriguez</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>George J. Rodriguez</u>					22e. ADDRESS <u>6th South Charles Street, Baltimore, Md.</u> <u>F.H.C. - University of Maryland Hospital</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 3/21/85		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board					25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE <u>Julian Davidson-Randall</u>		

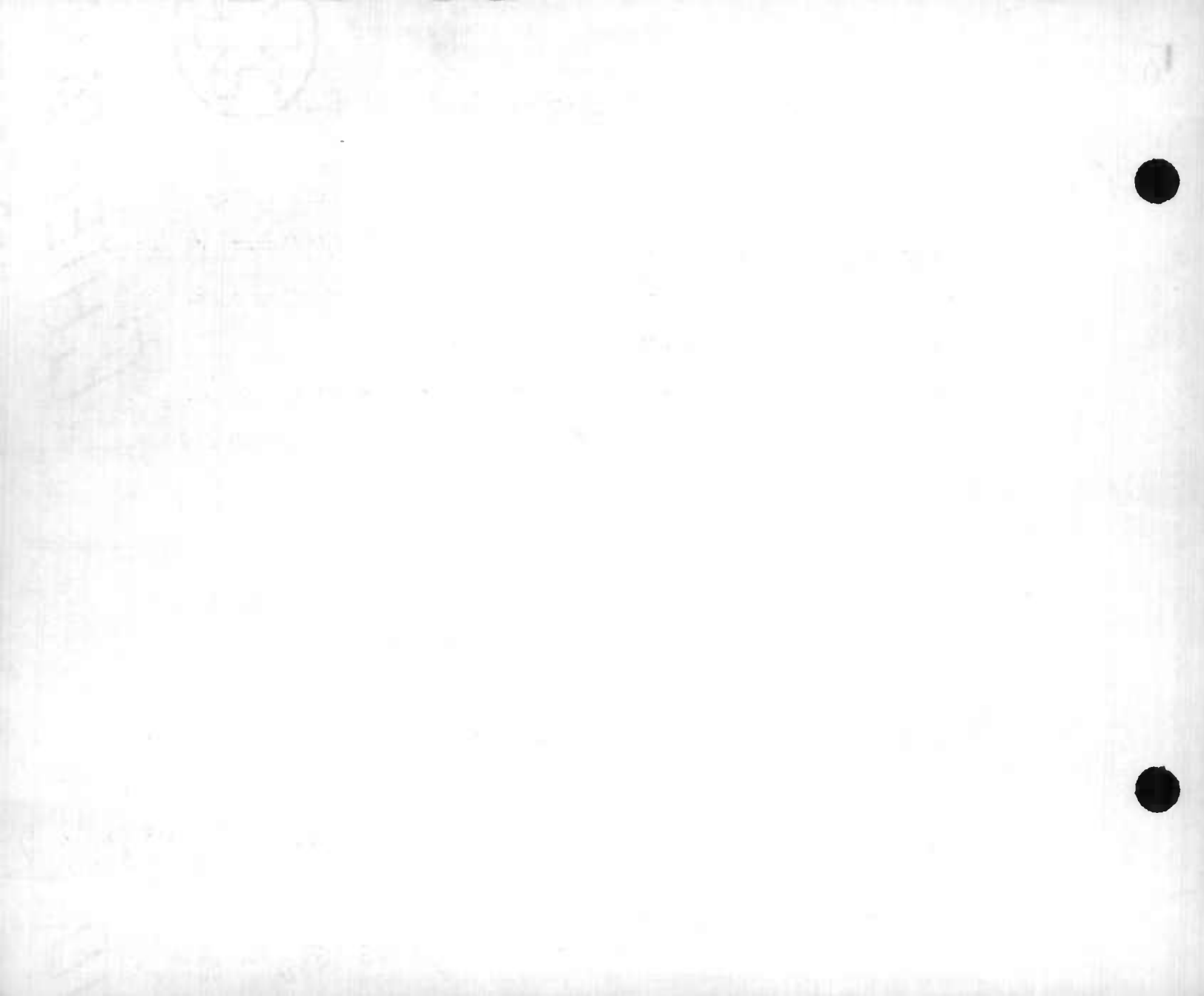
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.																			
1- STATE REGISTRAR				1 DECEASED NAME (TYPE OR PRINT) FIRST <i>John</i> MIDDLE LAST <i>Sauers</i> <i>SAUERS</i>				2a DATE OF DEATH MONTH DAY YEAR 3/17/85 3-17-85				2b HOUR 6:25 PM											
3 SEX Male M				4 RACE WHITE				5 DATE OF BIRTH MONTH DAY YEAR 7 25 05				6 AGE (IN YEARS LAST BIRTHDAY) 79				7 IF UNDER 1 YEAR MONTHS DAYS				8 IF UNDER 74 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.											
10 CITY OR TOWN OF DEATH Baltimore				11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center								12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Retired				12b KIND OF BUSINESS OR INDUSTRY Laborer							
13a STATE Maryland				13b COUNTY				13c CITY OR TOWN Baltimore				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET ADDRESS 6319 Elliott Street 21224							
14 FATHER'S NAME FIRST Henry MIDDLE LAST Sauers				15 MOTHER'S MAIDEN NAME MIDDLE LAST ? Matilda																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-05-6623				17 INFORMANT ADDRESS Matilda Ratajczak 1022 S. Highland Ave. 21224															
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPSIS																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF (b) upper respiratory infection																							
DUE TO, OR AS A CONSEQUENCE OF (c) influenza																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a																							
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE															
22a I certify that (I) (this hospital) attended the deceased from 3/8 19 85, to 3/17 19 85, that (I) (we) last saw the deceased alive on 3/8 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.																							
22b SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 3/18/85											
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS																			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 3-20-85				23c NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus				23d LOCATION CITY OR TOWN COUNTY STATE Dundalk, Balto. Co. Md.											
24 FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.				ADDRESS 901 S. Conkling St.				25a DATE RECD BY REGISTRAR 25b REGISTRAR'S SIGNATURE MAR 20 1985															

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Charles J. Eichen & Son Inc. 1717 Madison St.



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UNITED STATES

DEPARTMENT OF THE ARMY

FORM NO. 100-100



074049

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

U 8 0 5 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bertha E. Scanlon				2a. DATE OF DEATH MONTH DAY YEAR 3-12-85		2b. HOUR 4 55 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-9-19		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ----	
13a. STATE Md.				13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS / ZIP CODE 121 N. Ellwood Ave. 21224.	
14. FATHER'S NAME FIRST MIDDLE LAST Henry --- Schneider				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna --- ??			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Baltimore ADDRESS Md. 21231 Bertha Ann Nine-1751 E. Pratt St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) ventricular function failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) gastrointestinal bleed.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 days	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD							
19a. DATE OF OPERATION 3/11/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastrointestinal bleed		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/9 19 85 to 3/12 19 85, that (I) (we) lost saw the deceased alive on 3/12 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. D. [Signature] MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/14/85		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park-Glen Burnie-AA- Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME John A. Moran, Inc. Funeral Home 3000 E. Baltimore St.-Balto., Md. 21224				25a. DATE REC'D. BY REGISTRAR MAR 13 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Madeline B Scheder</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 2, 1985</b>			2b. HOUR M				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-6-1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6301 Fernbank Ave</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Sales Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>May Co.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6301 Fernbank Ave. 21214</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank A. Rosenberger</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leona Litz</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-16-8051</b>		17. INFORMANT ADDRESS <b>Severna Pk, Md.</b> <b>Frank L. Scheder, 381 Stonehouse Dr.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Colon with liver meta.</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ascitis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/12/1985</b> , 19 <b>85</b> , to <b>Feb 19 85</b> , that (I) (we) last saw the deceased alive on <b>2/12/1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Mukund S Didolkar</b>			DEGREE			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mukund S Didolkar M.D.</b>			22e. ADDRESS <b>University Hospital Baltimore, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-5-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Balto., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1985</b>		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 0 6 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MILDRED A. MIDDLE LAST SCHEELER			2a. DATE OF DEATH MONTH DAY YEAR 3-25-85			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02-13-22		6. AGE (IN YEARS LAST BIRTHDAY) 73 - YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY							

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY U.S.A.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1446 BOYLE ST. 212308C		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN ----- WALL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GENIVEVE ----- SCHMIDT								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-28-3444			17. INFORMANT Mr. John E. Scheeler, Sr.			ADDRESS 7624 3rd. Ave. C. B. 21061		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Early acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>congestive Heart Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> , 19 <u>85</u> , to <u>3/25</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/25</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.							
22b. SIGNATURE W. Rahming M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAHMING				22e. ADDRESS 30001 S. HANOVER ST. 21230			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 28, 1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME McClully Funeral Home, 130 E. Fort Ave. Balto. Md.				25a. DATE REC'D. BY REGISTRAR MAR 27 1985		25b. REGISTRAR'S SIGNATURE Davidson-Randall	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted and a medical certification completed.

BP

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(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Scheinin			2a. DATE OF DEATH MONTH DAY YEAR 3 17 1985		2b. HOUR 11:45 M
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 25 1900	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE
13a. STATE MD			13b. COUNTY BALTO	13c. CITY OR TOWN BALTO	
14. FATHER'S NAME FIRST MIDDLE LAST LABEL SCHEININ			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REVA UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WWII-ARMY 001-63-430		17. INFORMANT MRS. SOPHIE SCHEININ 3709 KINGWOOD SQ. BALTO., MD 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIO PULMONARY Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/14/85, 19 85, to 3/17, 19 85, that (I) (we) lost saw the deceased alive on 3/17/85, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.					
22b. SIGNATURE R. BEEM		DEGREE		22c. DATE SIGNED 3/17/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. BEEM		22e. ADDRESS SINAI HOSPITAL of BALTO.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 19, 1985	23c. NAME OF CEMETERY OR CREMATORY TZEMECH SEDEK VE SHOMREI HADATH BALTIMORE		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR MAR 22 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

04-100





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mabel D Scherbut			2a. DATE OF DEATH MONTH DAY YEAR 3/17/85			2b. HOUR 7:45 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 12 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. MD.				
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 835 E. Lombard St. 21202	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Riffin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Lane						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-14-4731		17. INFORMANT Susan Mason			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Atrial Fibrillation.								Years		
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. Diabetes, Possible Sepsis, S/P MI.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from March 1, 1985, to March 17, 1985, that (I) we last saw the deceased alive on March 17, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.										
22b. SIGNATURE Kevin Ferente MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3/18/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEVIN FERENTE MD					22e. ADDRESS JL Deaton Med Ctr.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 3 20 85		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR Name Deaton Medical Center 322 S. HIGGINS					25a. DATE REC'D. BY REGISTRAR MAR 19 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

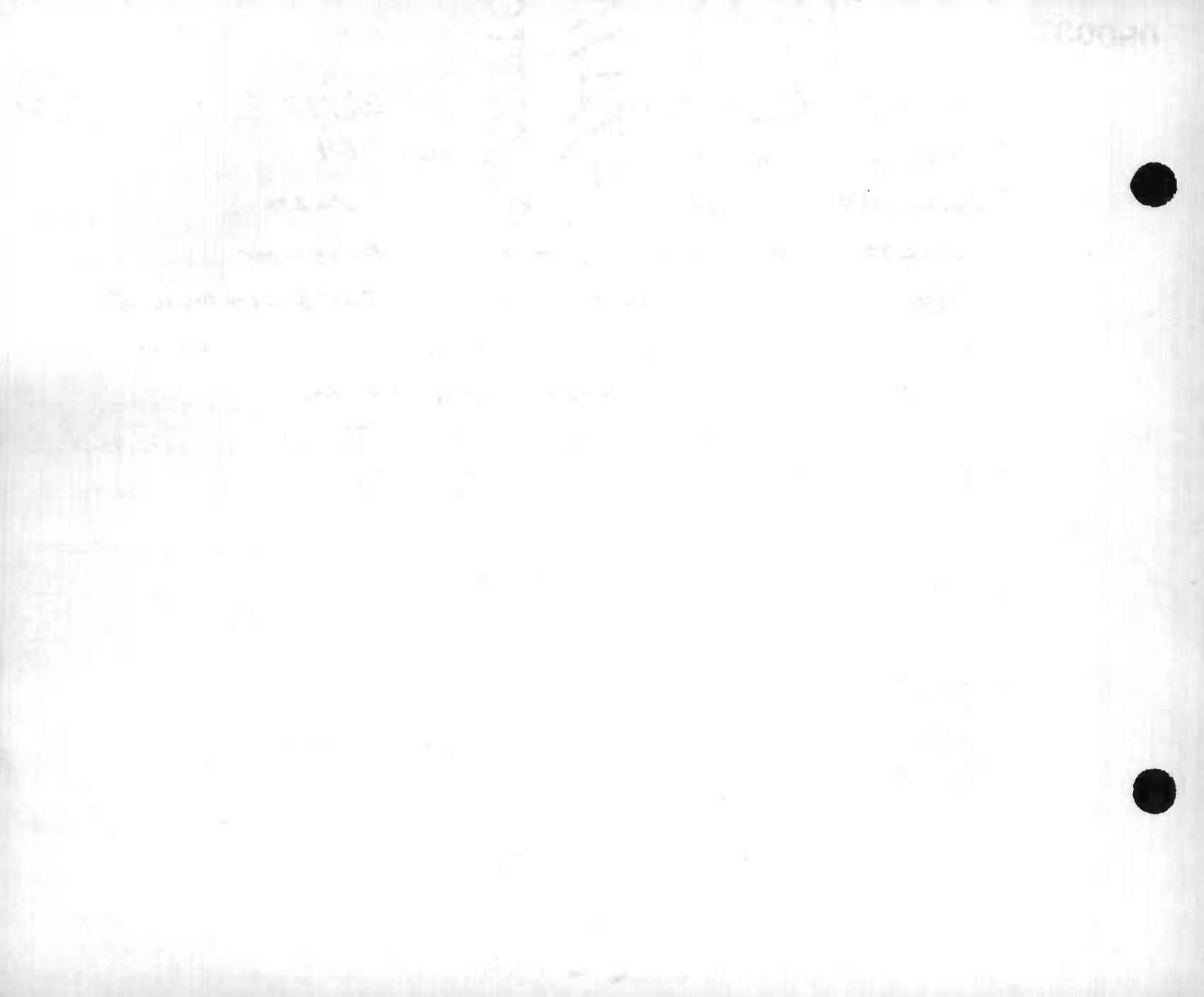
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>IRVING K. SCHEUER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>March 1, 1985</b>		2b HOUR <b>12:55PM</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>April 16, 1919</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired State of Maryland</b>		12b KIND OF BUSINESS OR INDUSTRY
13a STATE <b>Maryland</b>		13b COUNTY <b>Howard</b>	13c CITY OR TOWN <b>Jessup</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>late Edgar Scheuer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Mildred Lewis</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 11 20303 0442</b>		17 INFORMANT ADDRESS <b>Mrs Verna Scheuer 7915 Old Jessup Rd 20794</b>	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA PANCREAS OR COLON</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES MELLITUS: LIVER CIRRHOSIS</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19 85</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>February 15, 85</b> to <b>March 1, 19 85</b> , that (I) (we) last saw the deceased alive on <b>March 1, 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (www) (did) (did not) saw the body after death.					
22b SIGNATURE <b>A.F. Nazemi</b>		DEGREE <b>M.D.</b>		22c DATE SIGNED <b>3/1/85</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>A.F. NAZEMI, M.D.</b>		22e ADDRESS <b>CHURCH HOSPITAL 100 N. BROADWAY, BALTO., MD 21231</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>March 5, 1985</b>		23c NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>Howard Maryland</b>		24 FUNERAL DIRECTOR NAME ADDRESS <b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>			
25a DATE REC'D. BY REGISTRAR <b>MAR 4 1985</b>		25b REGISTRAR'S SIGNATURE <b>Wanda Pender</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 of this certificate must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 of this certificate must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

08-11-20



20/11/21

100103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called upon.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD SCHIMMEL					2a. DATE OF DEATH MONTH DAY YEAR 3 29 85				2b. HOUR 7:15 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 7, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HEALTH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASST. DIRECTOR		12b. KIND OF BUSINESS OR INDUSTRY MD. ACADEMY OF SCIENCE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTO. 13c. CITY OR TOWN BALTIMORE					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6712 ALTER ST. #21207				
14. FATHER'S NAME FIRST MIDDLE LAST DAVID SCHIMMEL					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE APPEL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 212-20-2582		17. INFORMANT GOLDIE SCHIMMEL 6712 ALTER ST. BALTO., MD 21207				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) NEW LEFT BUNDLE BRANCH BLOCK DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) URINARY TRACT INFECTION WITH SEPSIS AND DEHENTIA											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21e. PLACE OF INJURY			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/29, 19 85, to 3/29, 19 85, that (I) (we) last saw the deceased alive on 3/29, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John Thomas Evelius						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/29/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Thomas Evelius						22e. ADDRESS UNION MEMORIAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE MAR. 31, 1985		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM. PARK			23d. LOCATION BALTIMORE COUNTY MARYLAND			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR APR 4 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

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Film G602 item 23a, 23b, 23c

FOR 1/1/85 rja  
1 - STATE REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

08065

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARTIN R. SCHWALLENBERG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/27/85</b>		2b. HOUR <b>6:50PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 15 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LITHOGRAPHER</b>		
						12b. KIND OF BUSINESS OR INDUSTRY <b>PRINTING</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE SCHWALLENBERG</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY AGNES CURRAN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>212-01-2511</b>		17. INFORMANT ADDRESS <b>HILDA MAY SCHWALLENBERG 3036 STRICKLAND ST. 21223</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>peritonitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Colonic perforation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>12 d</b> <b>12 d</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Histiocytic lymphoma</b>								
19a. DATE OF OPERATION <b>3/15/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Colonic perforation</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>5/14</b> , 19 <b>85</b> , to <b>3/27</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/27</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Caryn C. Wunderlich MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/27/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Caryn C. Wunderlich</b>				22e. ADDRESS <b>ST. AGNES HOSPITAL, 900 S. CATON AVENUE 21229</b>				
23a. BURIAL, CREMATION, REMOVAL <b>Entombment</b>		23b. DATE <b>04/02/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 29 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		
ADDRESS <b>4107 WILKENS AVE.</b>								

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
ANNIE D. SCOTT					3	23	85		9:10 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female	Black	MONTH DAY YEAR 1 5 18		67	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
S. Carolina	U.S.A.			BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE	UNION MEMORIAL HOSPITAL								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland				Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		721 East 22nd St. 21218		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Harry Taylor		FIRST MIDDLE LAST Annie Shephard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		N/A		Jeanetta Holmes 720 N. Mount Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Massive Brainstem Infarct DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Hx of MI									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/20, 19 85, to 3/23, 19 85, that (I) (we) lost saw the deceased alive on 3/23, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Bernita C. Taylor MD						3/23/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Bernita C. Taylor MD		UNION MEMORIAL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE	
BURIAL		3/28/85		Baltimore Cemetery		Baltimore, CITY OR TOWN		Md. COUNTY	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm C March F/H Inc. 1101 E North Avenue				MAR 26 1985		Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



085041



NOTE

NOTE

BALTIMORE CITY

UNION MEDICAL HOSPITAL

BALTIMORE

UNION MEDICAL HOSPITAL



080107

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BABY STEVEN BOY WYLEY SCOTT JR.			2a. DATE OF DEATH MONTH DAY YEAR 3-15-85			2b. HOUR 1:50A <sub>M</sub>			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12-11-84		6. AGE (IN YEARS LAST BIRTHDAY) 3 months YRS		IF UNDER 1 YEAR MONTHS DAYS 3 3	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. CITY OR TOWN BALTIMORE		13c. STREET ADDRESS / ZIP CODE ST. AGNES HOSPITAL 21229				
14. FATHER'S NAME FIRST MIDDLE LAST STEVEN SCOTT Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE ALLIST WYLEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS STEVEN SCOTT, Sr. 5605 Wayne Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> <u>7651</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PREMATURITY WITH HYALINE MEMBRANE DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>INTRAVENTRICULAR AND PULMONARY HEMORRHAGE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>&lt; 5 min</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>HEPATOMEGALY WITH SECONDARY DIC AND ASCITES</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>12-14-1984</u> 19 to <u>3-15</u> 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>3-15</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Nancy Baker, MD</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>3-15-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>NANCY BAKER, MD</u>					22e. ADDRESS <u>ST. AGNES HOSPITAL</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>3/18/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KING MEM. PARK</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTO., MD.</u>		
24. FUNERAL DIRECTOR NAME <u>LEROY O. DYETT</u>					25. DATE REC'D. BY REGISTRAR <u>MAR 19 1985</u>		25. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

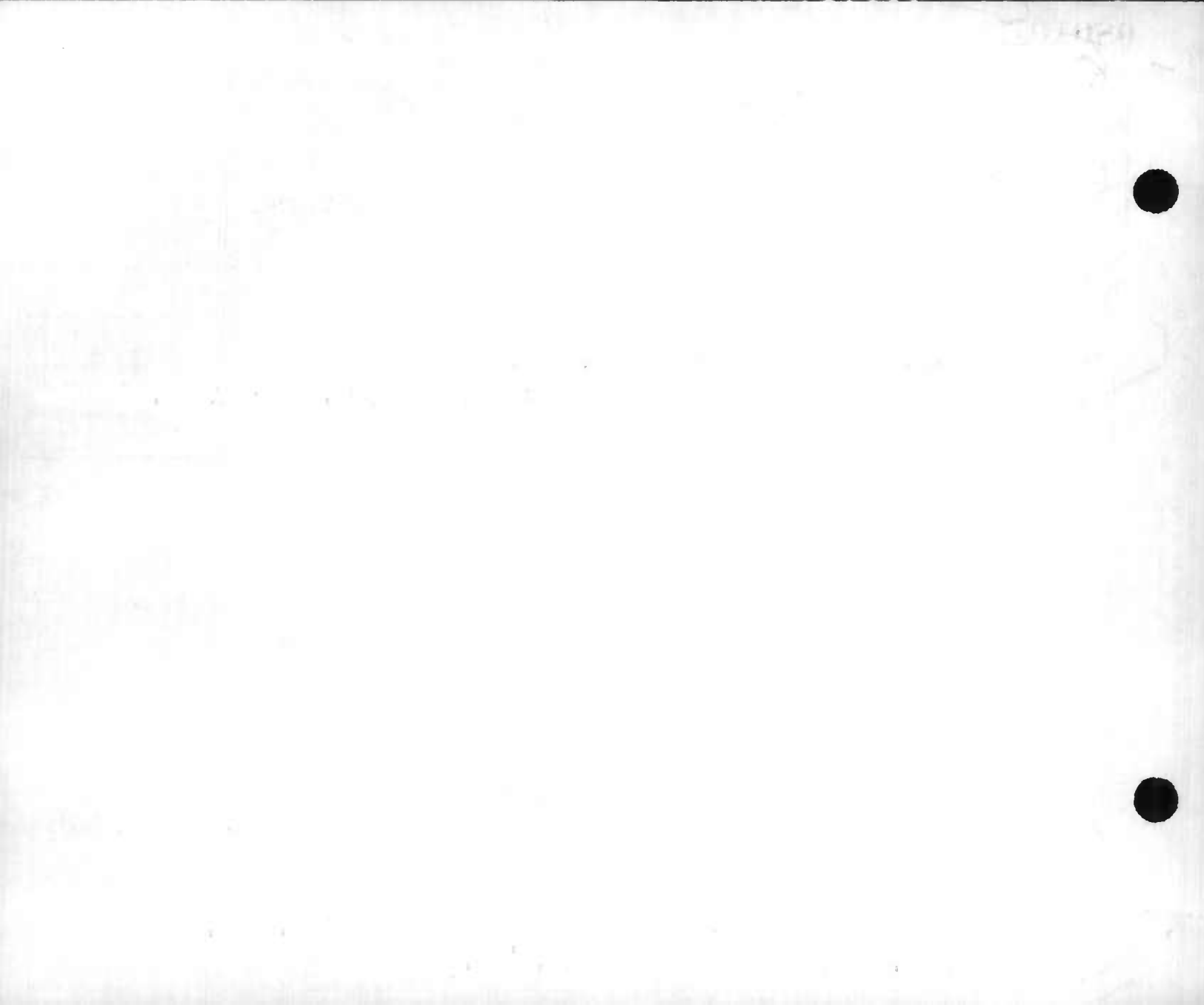
MUST BE OBTAINED BY THE MEDICAL EXAMINER

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



078022

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 SEP 095860 6 8

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Blanche Masse Scrivener			2a. DATE OF DEATH MONTH DAY YEAR 3 16 85		2b. HOUR 9:15 AM
3. SEX F female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 29 08	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) (a) STATE (b) COUNTY (c) CITY OR TOWN Maryland Baltimore Catonsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Massey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Boyd		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-74-8653	17. INFORMANT ADDRESS Charles R. Scrivener Same as 3 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>Years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/1/85</u> to <u>3/16/85</u> , that (I) (we) last saw the deceased alive on <u>2/8/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Adnan M. Sonmez</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adnan M. Sonmez		22e. ADDRESS 500 N. Rolling Ct. Md. 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/19/85	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Md.
24. FUNERAL DIRECTOR NAME L. B. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228			25a. DATE REC'D. BY REGISTRAR MAR 18 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and, if necessary, by the funeral director, page 2 should be detached for use on the burial/transfer permit. Their please remove carbon papers. Pages 3 and 4 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
JOSEPH JOHN SERIO			MARCH 26, 1985			10:00 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	Caucasian	Nov. 5, 1913	71 YRS.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Balto, Md.	USA			BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	VA MEDICAL CENTER BALTIMORE MD			Produce Clerk			Market Lexington	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland						Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13d. STREET ADDRESS / ZIP CODE		
Salvatore Serio			Sara Serio			3125 Mareco Ave, 21213		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Yes WWII			215-07-3286			Mary Serio, Wife, same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Transitional Cell Bladder Ca</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 18, 1985</u> to <u>March 26, 1985</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Marc- 26, 1985</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.								
22b. SIGNATURE <u>Neil Padgett MD MPH</u>			DEGREE			22c. DATE SIGNED <u>3/26/85</u>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22d. ADDRESS					
Neil Padgett, M.D. MPH			3900 Loch Raven Blvd. Baltimore MD 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			3/29/85			Crownsville Vet Cen. Crownsville, Md.		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Schimunek Funeral Home, Balto, Md. 21213			MAR 29 1985			<u>Paula T. Anderson</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Film G602 item 1

FOR 4/25/85 rja  
1. STATE REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH L SEVERSON</b>		2a. DATE OF DEATH MONTH <b>3</b> DAY <b>30</b> YEAR <b>85</b>		2b. HOUR <b>5:50</b> AM
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>04</b> DAY <b>05</b> YEAR <b>00</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Still Pond, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, Md.</b>
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>B.G. &amp; E.</b>
13a. STATE <b>Md.</b>		13b. COUNTY <b>Catowille</b>	13c. CITY OR TOWN <b>Beth</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>Severson</b> LAST <b>Severson</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Sadie</b> MIDDLE <b>Crew</b> LAST <b>Crew</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>212056329</b>		17. INFORMANT ADDRESS <b>6811 Campfield Rd. Md. -21207</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a.

**Pneumonia; Debridement; organic brain syndrome**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from **3-29-85** to **3-30-85**, that (I) (we) last saw the deceased alive on **3-29-85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

**DAR SHAN S. SALUJA****1600 MT Roy al Ave, Balto 21217**23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY) **Burial**23b. DATE  
**4-2-85**23c. NAME OF CEMETERY OR CREMATORY  
**Baltimore Cemetery**23d. LOCATION  
CITY OR TOWN **Balto. Md.** COUNTY STATE

24. FUNERAL DIRECTOR

**John C. Miller Inc-6415 Be lair Rd.-21206**25a. DATE RECEIVED BY REGISTRAR **APR 2 - 1985** 25b. REGISTRAR'S SIGNATURE **W. J. Anderson**TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 to be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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038017

Still not, M.

(Noted for review)

Smith, J.

Under the name of J. Smith  
A. Smith, J. Smith, J. Smith  
J. Smith, J. Smith, J. Smith



Calto. 10.

Baltimore (Western)

4-2-64

Smith

Mr. J. Smith Inc. - 117 E. Main St. - Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 08071			
1. DECEASED NAME (TYPE OR PRINT) <u>JOHN L. SEWARD</u>						2a. DATE OF DEATH MONTH <u>3</u> DAY <u>6</u> YEAR <u>1985</u>				2b. HOUR <u>10:30 P.M.</u>	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>5</u> DAY <u>28</u> YEAR <u>1910</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u> YRS		IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>		IF UNDER 24 HRS HOURS <u>  </u> MIN. <u>  </u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Ind.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.					
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>102 S. Carrollton Ave. 21223</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Helper</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>B+O. R. R.</u>			
13a. STATE <u>Ind.</u>		13b. COUNTY <u>  </u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>102 S. Carrollton Ave. 21223</u>			
14. FATHER'S NAME FIRST <u>Edw. Jr.</u> MIDDLE <u>  </u> LAST <u>Seward</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Lidia</u> MIDDLE <u>  </u> LAST <u>Zwanzger</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. <u>Dr. N. H.</u>		17. INFORMANT <u>Lidia Smith</u>				ADDRESS <u>102 S. Carrollton Ave. 21223</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIORESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBRO-VASCULAR ACCIDENT &amp; PT. HEMIPLEGIA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>  </u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>  </u> P.M. <u>  </u> 19 <u>  </u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>11/23/78</u> 19 <u>78</u> to <u>2/14/85</u> 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>2/14/85</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Lidia M. Jumanoy, M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>3/7/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LYDIA M. JUMANOY, M.D.</u>						22e. ADDRESS <u>101 S. CARROLLTON ST. BALTO. MD. 21201</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>				23b. DATE <u>3-9-1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR NAME <u>John J. Conner &amp; Son Inc.</u> ADDRESS <u>901 Hollins St.</u>						25a. DATE REC'D. BY REGISTRAR <u>MAR 12 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Lidia Davidson-Randall</u>			

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 0 8 0 7 2  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) Katharina Charlotte Seybold		MONTH DAY YEAR 3 8 85		8:00 PM	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3 3 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Cafeteria Manager
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Severna Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Berhardt Ruske		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Lachmann		13e. STREET ADDRESS / ZIP CODE 628 Arleigh Road, Severna Park, Md 21146	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 812327423	17. INFORMANT Elaine Smith P.O. Box 401 Pasadena, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH + immediate
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute Renal failure					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-6-85, to 3-8-85, that (I) (we) last saw the deceased alive on 3-8-85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Malinda H. White		DEGREE MD		22c. DATE SIGNED 3-8-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Malinda H. White		22e. ADDRESS South Baltimore General Hospital, Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/11/85	23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR MAR 11 1985			
25b. REGISTRAR'S SIGNATURE John A. ...					

07120



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA J SHANHOLTZ			2a. DATE OF DEATH MONTH DAY YEAR 3 13 85		2b. HOUR 4:15 AM	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6/25/18		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) F.S. KEY MED. CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE	
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JONES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET JONES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 235-30.0284		17. INFORMANT ADDRESS WEIL SHANHOLTZ ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PERFORATED LARGE BOWEL</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours 2 DAYS 1 WEEK
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PNEUMONIA, POOR NUTRITION</u>						
19a. DATE OF OPERATION 3/5/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED BOWEL			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 22, 1985</u> , to <u>MARCH 13, 1985</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 13, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Kevin Bellups MD		DEGREE			22c. DATE SIGNED 3/13/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BELLUPS, KEVIN		22e. ADDRESS FRANCIS SCOTT KEY MED CENTER				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL BURIAL		23b. DATE 3/15/85		23c. NAME OF CEMETERY OR CREMATORY ODDFELLOWS CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ELK GARDEN W. VA.
24. FUNERAL DIRECTOR NAME J.B. CONNELLY		ADDRESS 300 MACE AVE		25a. DATE REC'D. BY REGISTRAR MAR 19 1985		
25b. REGISTRAR'S SIGNATURE [Signature]						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical record must be completed and retained.

087098

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 5 0 8 0 7 4	
1 - STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MIRIAM M. SHAPIRO						2a DATE OF DEATH MONTH DAY YEAR MARCH 17, 1985			2b HOUR 5:50P <sup>AM</sup>		
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR OCT. 3, 1918		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5901 N. CHARLES ST.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b KIND OF BUSINESS OR INDUSTRY AT HOME		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY 13c CITY OR TOWN BALTIMORE 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e STREET ADDRESS / ZIP CODE 5901 N. CHARLES ST. 21210											
14 FATHER'S NAME FIRST MIDDLE LAST MYER MELNICOV						15 MOTHER'S MAIDEN NAME MIDDLE LAST GERTRUDE NEEDLE					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO (IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO. 218-12-0791B		17 INFORMANT ADDRESS ISRAEL D. SHAPIRO 5901 N. CHARLES ST. BALTO., MD 21210							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE MYELOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEVERAL WEEKS YEARS										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) <del>did not</del> attended the deceased from <u>March 16,</u> 19 <u>85</u> , to <u>March 17,</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>March 16,</u> 19 <u>85</u> , and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> view the body after death.											
22b SIGNATURE <i>John Mann</i>						DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED MARCH 18, 1985		
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MANN M.D.						22e ADDRESS 611 PARK AVENUE BALTO., MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE MARCH 19/85		23c NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO (ARLINGTON)		23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND					
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC 6010 REISTERSTOWN ROAD						25a DATE REC'D BY REGISTRAR MAR 22 1985		25b REGISTRAR'S SIGNATURE <i>Davidson</i>			

MEDICAL CERTIFICATION



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20% COTTON FIBER

CHIEF XAM BOND



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074/31

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8075

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
EVELYN C SHARROCK

2a. DATE OF DEATH MONTH DAY YEAR  
03 05 85

2b. HOUR  
8:PM

3. SEX  
Female

4. RACE  
Cauc.

5. DATE OF BIRTH MONTH DAY YEAR  
March 13 1929

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.  
55

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
New York

7b. CITIZEN OF WHAT COUNTRY?  
USA

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
BALTIMORE CITY MD.

10. CITY OR TOWN OF DEATH  
BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
THE JOHNS HOPKINS HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Homemaker

12b. KIND OF BUSINESS OR INDUSTRY  
Home

13a. STATE  
Va.

13b. COUNTY  
Arlington

13c. CITY OR TOWN  
--

13d. INSIDE CITY LIMITS?  
YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE  
3612 S. 7th St. 22204

14. FATHER'S NAME FIRST MIDDLE LAST  
Robert Ferraro

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Elizabeth O'Keefe

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)  
no

16b. SOCIAL SECURITY NO.  
140-22-6912

17. INFORMANT ADDRESS  
Clifford J. Sharrock/3612 S. 7th St. Arlington VA.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) LOW CARDIAC OUTPUT  
DUE TO, OR AS A CONSEQUENCE OF (b) FIXED PULMONARY HYPERTENSION  
DUE TO, OR AS A CONSEQUENCE OF (c) MITRAL STENOSIS  
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 yrs. 20 yrs.

19a. DATE OF OPERATION  
3/5/85

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
MITRAL STENOSIS

20a. AUTOPSY?  
YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ AT WORK  
NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 3/5 19 85, to 3/5 19 85, that (I) (we) lost saw the deceased alive on 3/5 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (I) did not view the body after death.

22b. SIGNATURE  
G. J. MAGUIRE JR.

22c. DEGREE  
MD

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
G. J. MAGUIRE JR.

22e. ADDRESS  
JOHNS HOPKINS HOSPITAL

22f. DATE SIGNED  
3/5/85

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial

23b. DATE  
3/8/85

23c. NAME OF CEMETERY OR CREMATORY  
Arlington National

23d. LOCATION CITY OR TOWN COUNTY STATE  
Arlington, VA.

24. FUNERAL DIRECTOR NAME ADDRESS  
Murphy Funeral Home 4510 Wilson Blvd. Arlington, VA.

25a. DATE REC'D. BY REGISTRAR  
MAR 11 1985

25b. REGISTRAR'S SIGNATURE  
Julia Davidson-Randall

999999

RETIRED AS NON-MED DR SMITH PER MR. HENRY

1 214 95 21 A

HOSPITAL OF ATTENDING PHYSICIAN. The hospital certifies that the death certificate was executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is filed, the attending physician and completely filled in by the funeral director, page 2 should be delivered to the funeral home. The funeral home should be delivered to the funeral home. The funeral home should be delivered to the funeral home.

IMPORTANT: If item 21 is not filled in, it shall be considered that the deceased died of natural causes, or other traumatic cause, or other traumatic cause, or other traumatic cause.

DHMH - 16 50M 4/83  
(VRA 15, 4)

8072



RECEIVED  
JAN 27 1964  
FBI - NEW YORK

NEW YORK

15 27 JAN 1964



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MELVIN L SHEPPARD			2a. DATE OF DEATH MONTH DAY YEAR 3/3/85			2b. HOUR 7:35 AM					
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 11 11 28			6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) unk		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md. Hospital.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unk		12b. KIND OF BUSINESS OR INDUSTRY unk.			
13a. STATE MD			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST RICHARD Y SHEPPARD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELEANOR GRANDY			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) unknown.			16b. SOCIAL SECURITY NO. 227 26 6461		
17a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest.			DUE TO, OR AS A CONSEQUENCE OF (b) Azotemia.			DUE TO, OR AS A CONSEQUENCE OF (c) Surgical absence of kidneys.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days. 6 years.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONTRIBUTING TO DEATH											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2/16, 19 85, to 3/3, 19 85, that (I) (we) last saw the deceased alive on 2/2, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ann Conjura MD			DEGREE			22c. DATE SIGNED 3/3/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANN CONJURA			22e. ADDRESS U. of Md. Hosp., 22 S. Greene St., Balt. MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-7-85		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balt. Md.				
24. FUNERAL DIRECTOR NAME Leroy O. Dyett			ADDRESS 4600 Liberty Hgts. Ave			25a. DATE REC'D. BY REGISTRAR MAR 5 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and consulted.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



078153

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Norman Sheppard</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>March 14 1995</i>		2b. HOUR M
3. SEX <i>Male</i>	4. RACE <i>negro</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 1, 1912</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1712 So Lafayette Ave.</i>		12a. USUAL OCCUPATION (TYPE OR INDUSTRY MOST OF WORKING (YRS)) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>1712 So Lafayette Ave.</i>		13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Sheppard</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Savage</i>		16. STREET ADDRESS, ZIP CODE <i>1117 Myrtle Ave. 21201</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-12-4488</i>		17. INFORMANT NAME ADDRESS <i>Joseph Sheppard 3622 Janet Smith Ave</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i> years DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerosis &amp; an aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chromosome Lung (oral report)</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Chromosome Lung (oral report)</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1984</i> 19 <i>85</i> to <i>1985</i> 19 <i>85</i> that (I) (we) last saw the deceased alive on <i>2-25-</i> 19 <i>85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>B. L. D. King</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>3/15/95</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>G. KING</i>		22e. ADDRESS <i>818 Huxley Ave Balt. 4201</i>			
23a. BURIAL, CREMATION, REMOVAL (CHECK) <i>Burial</i>		23b. DATE <i>3-19-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Hill Cem.</i>	
23d. LOCATION (CITY OR TOWN) COUNTY STATE <i>Baltimore City Md</i>		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Joseph H. Russ 2222 W. North Ave</i>		25. REGISTRAR'S SIGNATURE <i>C. Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

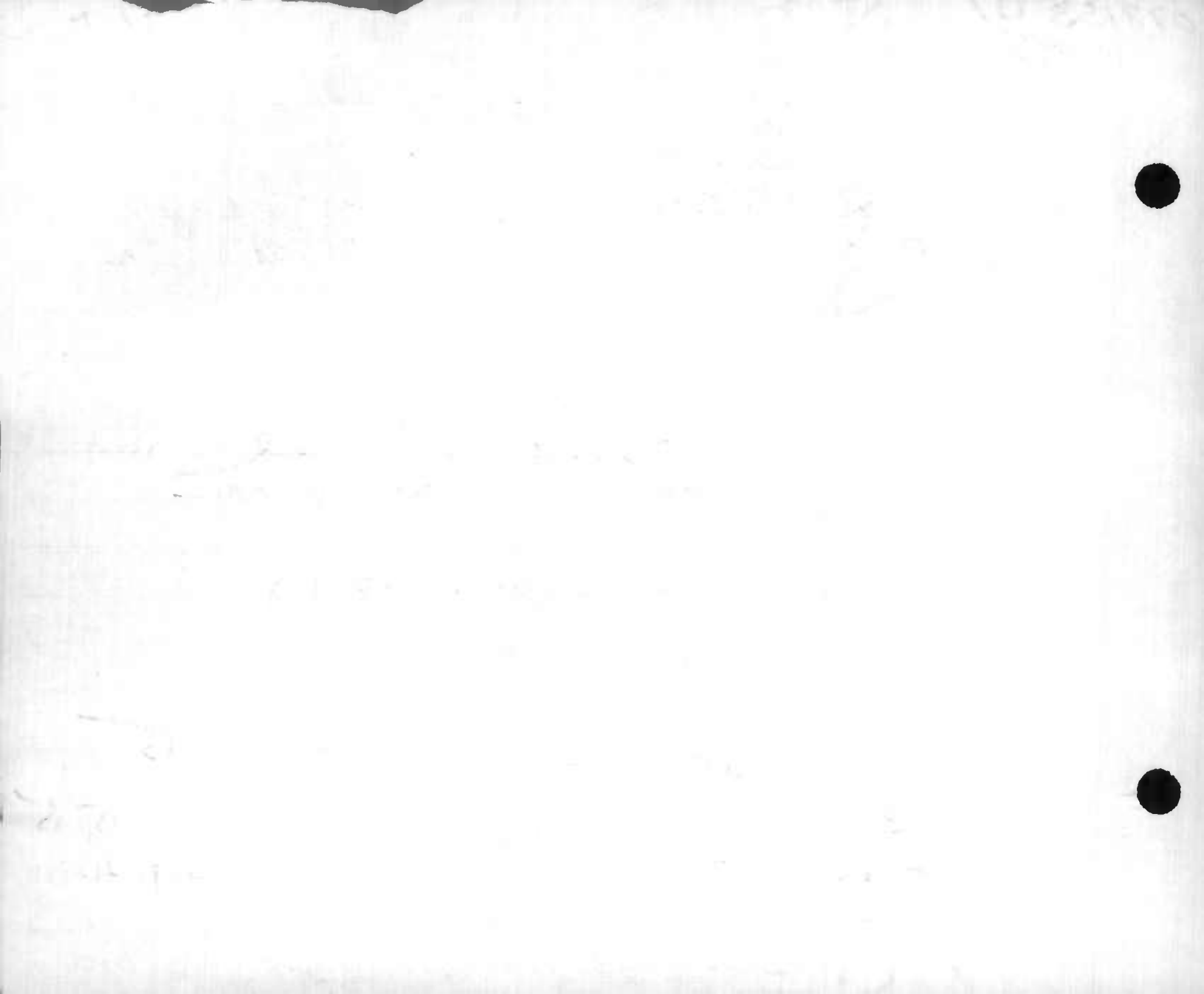
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Leonard L. Sherman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 4 85</b>		2b. HOUR MIN <b>6 P M</b>
1. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 6 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>67</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W VA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Security</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Det. Agency</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>931 Tally ct 21061</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Grover Sherman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN <input type="checkbox"/> IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>232-26-8172</b>		17. INFORMANT ADDRESS <b>Glen Burnie, Md. 21061</b> <b>Joann Skeranchak 931 Tally Court</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>weeks</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>spinal cord compression, diffuse intravascular coagulopathy</b>					
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>2-24</b> 19 <b>85</b> , to <b>3-4</b> 19 <b>85</b> , that (1) (we) lost saw the deceased alive on <b>3-4</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (do) (did not) view the body after death.					
22b. SIGNATURE <b>Linda A Headrick</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/4/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Linda A Headrick MD</b>		22e. ADDRESS <b>22 S. Greene St, Baltimore MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/8/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, Md. A.A.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Raymond C. Fink Glen Burnie, Md. 21061</b>			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>MAR 07 1985</b> <b>John Gordon Fordell</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page 35

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>THERESA M. SHERWOOD</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>3 6 85</b>		2b. HOUR <b>11 40</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 12 19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>219 S. GILMOR STREET, 21223</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT COLLINS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ALICE WOOLSEY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-78-7119</b>		17. INFORMANT ADDRESS <b>WILLIAM SHERWOOD 219 S. GILMOR STREET, 21223</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ELECTROLYTE IMBALANCE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MULTIPLE MYELOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL E. PELCZAR, M.D.</b>				22c. ADDRESS <b>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</b>				22d. DATE SIGNED <b>3/7/85</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>03-09-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>		25a. DATE REC'D BY REGISTRAR <b>MAR 8 1985</b>	
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1 DECEASED NAME (TYPE OR PRINT) <i>David Lee Shiflett</i>			MONTH DAY YEAR <i>3 29 85</i>			HOURS MIN. <i>12<sup>29</sup> P.</i>		
3. SEX <i>male</i>	4 RACE <i>white</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>1-14 1939</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>46</i> YRS.			7. UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>S. Balto Gen Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Construction</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Labor</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>			13b. CITY OR TOWN <i>Baltimore</i>			13c. STREET ADDRESS / ZIP CODE <i>Balto, Md. 1407 COVINGTON ST 21230</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Procy Edward Shiflett</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ruth E. Westcott</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>219 26 032</i>			17. INFORMANT ADDRESS <i>Wife same as Above</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>status post myocardial infarction 1983, 1984</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>3/29 1985</i> to <i>3/29 1985</i> , that (I) (we) lost <i>saw the deceased alive on 3/29 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>R.H. COOKE MD</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>3/29/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.H. COOKE</i>			22e. ADDRESS <i>3001 S. Hanover St Balto 21230</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b. DATE <i>Mar. 30, 1985</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Security Process Crem. Inc.</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Catonsville, Balto. Co. Md.</i>			23e. NAME OF FUNERAL HOME <i>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</i>			23f. BY REGISTRAR 23g. REGISTRAR'S SIGNATURE <i>APR 2 1985</i>		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE FREDERICK SHINNAMON</b>			2a. DATE OF DEATH MONTH <b>03</b> DAY <b>27</b> YEAR <b>1985</b>			2b. HOUR <b>7<sup>40</sup> AM</b>	
1. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>05</b> DAY <b>10</b> YEAR <b>1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AUTO MECHANIC</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>POST OFFICE</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>HALETHORPE</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1709 ARBUTUS AVENUE, 21227</b>	
14. FATHER'S NAME FIRST <b>FREDERICK</b> MIDDLE <b>G.</b> LAST <b>SHINNAMON</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ELLA</b> MIDDLE <b>DENNIS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW I 213-10-6520</b>		17. INFORMANT ADDRESS <b>21227 E. DONALD SHINNAMON 1709 ARBUTUS AVENUE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia, Renal failure,</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Colon Cancer, CVA, urinary tract infect.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/11</u> , 19 <u>85</u> , to <u>3/27</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/27</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Moonhee Lee</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/27/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lee, Moonhee</u>				22e. ADDRESS <u>St. Agnes Hosp.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>03-30-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEM. PK.</b>		23d. LOCATION CITY OR TOWN <b>ELKCRIDGE</b> COUNTY <b>HOWARD</b> STATE <b>MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b> ADDRESS <b>4107 WILKENS AVE.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 29 1985</b>		25b. REGISTRAR'S SIGNATURE <u>John F. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation must be conducted.

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WILKINSON

NO. 100-2000

094140

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Virginia Shivers</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3-14-85</i>			2b. HOUR <i>1:45 AM</i>			
3. SEX <i>FEMALE</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 08 88</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Key Circle Hospice</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>D.C.</i>			13b. COUNTY <i>Washington</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <i>646 Newton Pl., N.W. #4</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lula Unknown</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>231 42 5645</i>		17. INFORMANT ADDRESS <i>James Jackson 2404 Pomeroy Rd/S.E., Wash., D.C.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal failure &amp; Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>2-11</i> 19 <i>85</i> to <i>3-14</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3-14</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Gulab</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GULAB M. SHAH</i>					22e. ADDRESS <i>2105, N. Charles St Baltimore</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>3-19-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Landover, Md.</i>		
24. FUNERAL DIRECTOR <i>Vann &amp; Williams, 4804 Ga. Ave., N.W., Wash., D.C.</i>					25a. DATE REC'D. BY REGISTRAR <i>MAR 28 1985</i>				
					25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>				







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.83  
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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>John Woodrow Short</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>3-4-85</u>			
3. SEX <u>male</u>				2b. HOUR <u>10:45AM</u>			
4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>6-29-11</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>73</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N/A Virginia USA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>South Baltimore General</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Police Supervisor</u>		12b. INDUSTRY <u>Md. Drydock</u>	
13a. STATE <u>MD</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>John H. Short</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mabel Seigler Sigler</u>		13e. STREET ADDRESS / ZIP CODE <u>620 N. Ave 21225</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>232-01-1132</u>		17. INFORMANT ADDRESS <u>Matilda L. Short Same as #13</u>			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-27</u> , 19 <u>85</u> , to <u>3-4</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3-4</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Charles R. Richards MD</u> DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3-4-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. muneses</u>				22e. ADDRESS <u>South Baltimore General</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3/7/1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, A.A. Co., Md.</u>	
24. FUNERAL DIRECTOR NAME <u>McCully Funeral Homes</u>				25. DATE REC'D. BY REGISTRAR <u>MAR 5 1985</u> REGISTRAR'S SIGNATURE <u>J. Davidson</u>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
Edward Siekierski		03 11 85		11 50 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male	White	MONTH DAY YEAR		YRS.	
		06 25 1910		74	
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MD.	U.S.A.			BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTO.	MERCY HOSP.		RETIRED		ELEC.
13a. STATE	13b. COUNTY	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE		
MD.	BALTO.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	833 S. LAKEWOOD AVE. 21224		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Francis Siekierski		ANNA BOGACZ			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES		216-01-9206		ANNA MALISZEWSKI 2910 FAIR AVE 21224	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Pneumonia</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) <u>COPD</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/11/85</u> , 19 <u>85</u> , to <u>3/11</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/11</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
William Waschen		MD		3/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
WILLIAM WASCHLER		MERCY HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		3-14-85		SAC HEART OF MARY	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS					
THOMAS J. SKARDA 2829 HUDSON ST.		MAR 15 1985		Julia Davidson-Randall	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSA SILVERMAN		2a. DATE OF DEATH MONTH DAY YEAR 3 27 85		2b. HOUR 12:15 A M	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 10 - 3 1908		6. AGE (IN YEARS (LAST BIRTHDAY)) 76 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW GERIATRIC CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS KIRSCH		15. MOTHER'S MAIDEN NAME MIDDLE LAST HILDA SHAPIRO			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-40 4037		17. INFORMANT MR. ALBERT SILVERMAN APT. D 2826 DAMASCUS CT. BALTO., MD 21209	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK NOT AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-29-82 to 3-26-85, that (I) (we) lost saw the deceased alive on 3-26-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE SILVERMAN	DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3-27-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SEI H TOWAR		22e. ADDRESS Levindale Hebrew Geriatric Center 2434 Belvedere Ave, Baltimore, Md. 21215	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MAR. 29, 1985	23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH	23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 2010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR APR 2 - 1985	25b. REGISTRAR'S SIGNATURE

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLARKE W. SIMMERS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 1 85</b>			2b. HOUR <b>8:25</b> AM	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 26 41</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>43</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Butcher</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Food-a-Rama</b>		13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Herbert Schmidt</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Keirle</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>647 S. Wickham 21229</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-38-7033</b>		17. INFORMANT ADDRESS <b>Gertrude Simmers 647 S. Wickham Rd. 21229</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardio Vascular Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetic Mellitus, Obesity, 1/2 hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>							
19a. DATE OF OPERATION <b>2/9</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/1</b> , 19 <b>75</b> , to <b>3/1</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>10/30</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Cliff Ratliff, Jr.</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/4/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Cliff Ratliff, Jr.</b>				22e. ADDRESS <b>5772 WESTVIEW MALL, 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/5/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Kyesville Carroll Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





per call w/F.H. #6,3/28/85 kam  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

3 091083

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR C. Simmons			2a. DATE OF DEATH MONTH DAY YEAR March 18, 1985			2b. HOUR 4 P.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct. 3, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Unkn		13e. STREET ADDRESS / ZIP CODE 527 Pontiac AVE 21225			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 21055105		17. INFORMANT Ethel Simmons (same as 13e)			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
 PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Sepsis

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
1 day

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 5</u> , 19 <u>85</u> , to <u>March 18</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>March 18</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Harold Blumenthal, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>March 18, 1985</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HAROLD Blumenthal M.D.</u>				22e. ADDRESS <u>3001 J. Nanover St. Baltimore, Md. 21205</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3 21 85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem Pk</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Glen Burnie AA Md</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>George Gonce 4001 Ritchie Hwy Balto Md</u>				25a. DATE RECEIVED BY REGISTRAR <u>MAR 22 1985</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



0813851

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST <b>FRANK B. Simmons</b>		MONTH DAY YEAR HOUR <b>3-4-85 11:40 PM</b>	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Male	White	MONTH DAY YEAR <b>6 22 1906</b>	78 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	U.S.A.		Baltimore City MD
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Francis Scott Key Medical Center	Maintenance	Beth. Steel
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Maryland	Baltimore	Dundalk	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS / ZIP CODE	
FIRST MIDDLE LAST <b>Not Known</b>	FIRST MIDDLE LAST <b>Not Known</b>	1878 Marshall Road 21222	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	214-12-9487	Louise C. Simmons	Same as 13e
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>20 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 28</u> , 19 <u>85</u> , to <u>March 4</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>March 4</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
<u>D. Ellison</u>	MD	<u>3/5/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
<u>David Ellison</u>	<u>Johns Hopkins Hospital</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	3/8/1985	Oak Lawn	Baltimore Maryland
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
<u>Duda-Ruck, Inc.</u> <u>7922 Wise Avenue Dundalk, MD. 21222</u>		<u>MAR 7 1985</u> <u>He. Anderson</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



081087

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 0 8 9

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDNA Florence SIMMS			2a. DATE OF DEATH MONTH DAY YEAR MARCH 18, 1985		2b. HOUR P M 5:25
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 8, 1898	6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY ---	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY ---	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 418 N. Streeper St. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob D. Merriken		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary --- Heckman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---	17. INFORMANT Baltimore, Md. 21230 Jerome W. Merriken-20 E. Henrietta St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiovascular collapse</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>20 min</u> <u>5 hrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Cardiovascular disease</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/18, 1985</u> to <u>3/18, 1985</u> , that (I) (we) last saw the deceased alive on <u>3/18, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Micheline McCarthy		DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/18/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Micheline McCarthy		22e. ADDRESS Johns Hopkins Hospital / Baltimore, Md. 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Mar. 22, 1985	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Towson, Maryland	
24. FUNERAL DIRECTOR John A. Moran, Inc. Funeral Home 3000 E. Baltimore St., Balto., Md. 21224		DATE REC'D. BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE A. B. Davidson-Randall	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 10 days of death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or medical examiner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



081385

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 0 9 0

FOR  
1- STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>BERTIE E. SIMPERS</b>			2a DATE OF DEATH MONTH DAY YEAR <b>3 / 6 / 85</b>			2b HOUR <b>2:02 PM</b>					
3 SEX <b>F</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>5 / 17 / 30</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS <b>54</b>		8 IF UNDER 24 HRS HOURS MIN. <b>54</b>	
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9b CITIZEN OF WHAT COUNTRY? <b>USA</b>		10 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.					
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Factory worker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>B&amp;D</b>			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md.</b> 13b. COUNTY <b>Carroll</b> 13c. CITY OR TOWN <b>Manchester</b>				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>3519 Miller Station Rd 21102</b>					
14 FATHER'S NAME FIRST MIDDLE LAST <b>Chester Masimore</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn Leppo</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. <b>215268 690</b>		17 INFORMANT ADDRESS <b>Mr. George Simpser, Manchester, Md.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sub-arachnoid Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral Anoxia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72°</b>										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>	
19a DATE OF OPERATION <b>---</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>---</b>							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>---</b>		21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>---</b>							
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>[Signature]</b>						DEGREE <b>---</b>		22c DATE SIGNED <b>3/6/85</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Signature]</b>						22e ADDRESS <b>Mercy Hospital</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>3-9-85</b>		23c NAME OF CEMETERY OR CREMATORY <b>Immanuel Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Manchester Carroll Md.</b>					
24 FUNERAL DIRECTOR NAME <b>Eline Funeral Home, Hampstead, Md.</b>						25 DATE REC'D. BY REGISTRAR MAR 8 1985 REGISTRAR'S SIGNATURE <b>[Signature]</b>					

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



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081386

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

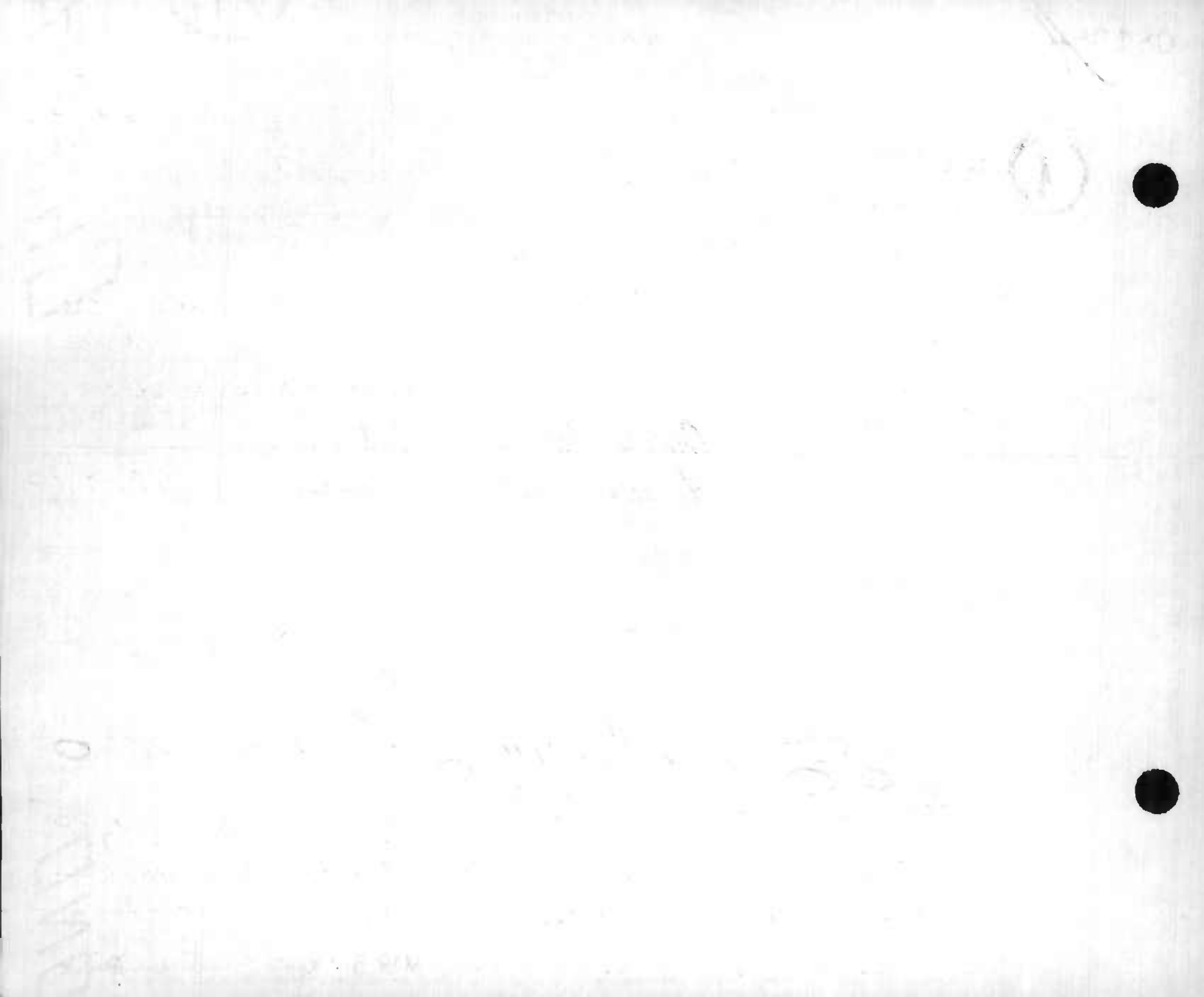
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Fannie</u> MIDDLE <u>R.</u> LAST <u>Simpson</u> (Sannie)			2a. DATE OF DEATH MONTH <u>3</u> DAY <u>2</u> YEAR <u>1985</u>			2b. HOUR <u>6:30</u> A.M.					
3. SEX <u>female</u>		4. RACE <u>black</u>		5. DATE OF BIRTH MONTH <u>2</u> DAY <u>22</u> YEAR <u>58</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>63</u> YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore city</u> MD.					
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>261 Colvin Street</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>Md</u>			13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>261 Colvin Street 21202</u>		
14. FATHER'S NAME FIRST <u>Quentin</u> MIDDLE <u></u> LAST <u>Baker</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Elsie</u> MIDDLE <u></u> LAST <u>Mitchel</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>			16b. SOCIAL SECURITY NO. <u>240-12-9012</u>		17. INFORMANT ADDRESS <u>Brenda Simpson 261 Colvin Street</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ALCOHOLIC LIVER DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>'79 -&gt; '85</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>N/A</u>											
19a. DATE OF OPERATION <u>N/A</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>N/A</u> P.M. <u>N/A</u> 19 <u>79</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>N/A</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <u>N/A</u>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) <u>N/A</u>			21f. LOCATION STREET <u>N/A</u> CITY OR TOWN <u>N/A</u> COUNTY <u>N/A</u> STATE <u>N/A</u>					
22a. I certify that (1) <u>(this hospital)</u> attended the deceased from <u>1-24</u> 19 <u>85</u> , to <u>1/24</u> 19 <u>85</u> , that <u>(I viewed)</u> saw the deceased alive <u>above</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>viewed</u> did not view the body after death.											
22b. SIGNATURE <u>Melva J. Brown, M.D.</u> DEGREE <u>M.D.</u>						22c. DATE SIGNED <u>3/4/85</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MELVA J. BROWN, M.D.</u>						22e. ADDRESS <u>3100 WYMAN PARK DRIVE</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>3/7/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Garrison Forest VA</u>			23d. LOCATION CITY OR TOWN <u>Owings Mills</u> COUNTY <u></u> STATE <u>MD</u>			
24. FUNERAL DIRECTOR NAME <u>William C. March F/H 1101 E. North Ave</u>						25a. DATE REC'D. BY REGISTRAR <u>MAR 5 1985</u>			25b. REGISTRAR'S SIGNATURE <u>Gelia Davidson-Randall</u>		

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAMIE L. Sims			2a. DATE OF DEATH MONTH DAY YEAR May 10 1985			2b. HOUR 11:20 AM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 1 09		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 833 W. Pratt St. Baltimore 21230	
14. FATHER'S NAME FIRST MIDDLE LAST Waverly Powell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celia Jackson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 230-01-2219		17. INFORMANT ADDRESS Waverly Jones 3602 Harlem Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C. Malayaman						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. MALAYAMAN M.D.						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-15-85		23c. NAME OF CEMETERY OR CREMATORY Pleasant Plain Cem		23d. LOCATION Branville Va. COUNTY STATE		
24. FUNERAL DIRECTOR NAME Chas. A. Rice ESPA 1300 Rutaw Pl						25a. DATE REC'D. BY REGISTRAR MAR 15 1985		25b. REGISTRAR'S SIGNATURE Celia Jackson	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Marguerite</b>			FIRST MIDDLE LAST <b>Sims</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 18 85</b>			2b. HOUR <b>7:00p M</b>		
3. SEX <b>Female</b>			4. RACE <b>Black</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 21 1917</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD		
10. CITY OR TOWN OF DEATH <b>Balto.</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4312 Dewey Ave.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Library Asst.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Library</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto</b>			13c. CITY OR TOWN <b>Balto</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Ennis</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Taylor</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>125-24-6084</b>		
17. INFORMANT ADDRESS <b>William Ennis 4312 Dewey Ave.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>3 years</b> <b>6 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Gastric ulcer/hatal hernia</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 25</b> 19 <b>85</b> to <b>Mar</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>Mar 6</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Sheila A. Walker</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3-19-85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sheila Walker</b>			22e. ADDRESS <b>4419 Falls Rd</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-21-85</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>			23d. LOCATION CITY COUNTY STATE <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Bailey-Douglass Fun. Home 1348 N. Calhoun St.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1985</b>			25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rendell</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial transit permit. Then please remove (or photocopy) the certificate and submit it to the State Dept. of Health and Mental Hygiene prior to burial/cremation. It is important that item 21 is completed or item 18 is completed in any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 8 0 9 4			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>AARON DAVID SINGER</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 13, 1985</b>				2b. HOUR <b>9:15 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 10, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Czechoslovakia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>							
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Executive Officer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>C.I.W. Geo. Lab.</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2509 Jennings Road (20902)</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Koppel Singer</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Esther Bodner</b>				ADDRESS <b>Maryland 20902</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		<b>579-24-6912</b>		17. INFORMANT ADDRESS <b>Frances A. Singer; 2509 Jennings Road; S. Spg.;</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic adenocarcinoma of the stomach</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>19 hours</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3/12 19 85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>3/12</b> 19 <b>85</b> to <b>3/13</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/13</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.										22b. SIGNATURE <b>George D. Bodner MD</b> DEGREE		22c. DATE SIGNED <b>3/13/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George D. Bodner</b>				22e. ADDRESS <b>% Johns Hopkins Hospital - Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/15/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Judean Memorial Gdns.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Olney; Montgomery; Maryland</b>							
24. FUNERAL DIRECTOR NAME ADDRESS <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b> <b>1170 Rockville Pike; Rockville, Md. 20852</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rondelle</b>							

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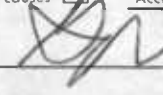
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. GIVE PAGE 6 TO THE MEDICAL EXAMINER. GIVE PAGE 7 TO THE FUNERAL DIRECTOR. GIVE PAGE 8 TO THE MEDICAL EXAMINER. GIVE PAGE 9 TO THE FUNERAL DIRECTOR. GIVE PAGE 10 TO THE MEDICAL EXAMINER. GIVE PAGE 11 TO THE FUNERAL DIRECTOR. GIVE PAGE 12 TO THE MEDICAL EXAMINER. GIVE PAGE 13 TO THE FUNERAL DIRECTOR. GIVE PAGE 14 TO THE MEDICAL EXAMINER. GIVE PAGE 15 TO THE FUNERAL DIRECTOR. GIVE PAGE 16 TO THE MEDICAL EXAMINER. GIVE PAGE 17 TO THE FUNERAL DIRECTOR. GIVE PAGE 18 TO THE MEDICAL EXAMINER. GIVE PAGE 19 TO THE FUNERAL DIRECTOR. GIVE PAGE 20 TO THE MEDICAL EXAMINER. GIVE PAGE 21 TO THE FUNERAL DIRECTOR. GIVE PAGE 22 TO THE MEDICAL EXAMINER. GIVE PAGE 23 TO THE FUNERAL DIRECTOR. GIVE PAGE 24 TO THE MEDICAL EXAMINER. GIVE PAGE 25 TO THE FUNERAL DIRECTOR. GIVE PAGE 26 TO THE MEDICAL EXAMINER. GIVE PAGE 27 TO THE FUNERAL DIRECTOR. GIVE PAGE 28 TO THE MEDICAL EXAMINER. GIVE PAGE 29 TO THE FUNERAL DIRECTOR. GIVE PAGE 30 TO THE MEDICAL EXAMINER. GIVE PAGE 31 TO THE FUNERAL DIRECTOR. GIVE PAGE 32 TO THE MEDICAL EXAMINER. GIVE PAGE 33 TO THE FUNERAL DIRECTOR. GIVE PAGE 34 TO THE MEDICAL EXAMINER. GIVE PAGE 35 TO THE FUNERAL DIRECTOR. GIVE PAGE 36 TO THE MEDICAL EXAMINER. GIVE PAGE 37 TO THE FUNERAL DIRECTOR. GIVE PAGE 38 TO THE MEDICAL EXAMINER. GIVE PAGE 39 TO THE FUNERAL DIRECTOR. GIVE PAGE 40 TO THE MEDICAL EXAMINER. GIVE PAGE 41 TO THE FUNERAL DIRECTOR. GIVE PAGE 42 TO THE MEDICAL EXAMINER. GIVE PAGE 43 TO THE FUNERAL DIRECTOR. GIVE PAGE 44 TO THE MEDICAL EXAMINER. GIVE PAGE 45 TO THE FUNERAL DIRECTOR. GIVE PAGE 46 TO THE MEDICAL EXAMINER. GIVE PAGE 47 TO THE FUNERAL DIRECTOR. GIVE PAGE 48 TO THE MEDICAL EXAMINER. GIVE PAGE 49 TO THE FUNERAL DIRECTOR. GIVE PAGE 50 TO THE MEDICAL EXAMINER. GIVE PAGE 51 TO THE FUNERAL DIRECTOR. GIVE PAGE 52 TO THE MEDICAL EXAMINER. GIVE PAGE 53 TO THE FUNERAL DIRECTOR. GIVE PAGE 54 TO THE MEDICAL EXAMINER. GIVE PAGE 55 TO THE FUNERAL DIRECTOR. GIVE PAGE 56 TO THE MEDICAL EXAMINER. GIVE PAGE 57 TO THE FUNERAL DIRECTOR. GIVE PAGE 58 TO THE MEDICAL EXAMINER. GIVE PAGE 59 TO THE FUNERAL DIRECTOR. GIVE PAGE 60 TO THE MEDICAL EXAMINER. GIVE PAGE 61 TO THE FUNERAL DIRECTOR. GIVE PAGE 62 TO THE MEDICAL EXAMINER. GIVE PAGE 63 TO THE FUNERAL DIRECTOR. GIVE PAGE 64 TO THE MEDICAL EXAMINER. GIVE PAGE 65 TO THE FUNERAL DIRECTOR. GIVE PAGE 66 TO THE MEDICAL EXAMINER. GIVE PAGE 67 TO THE FUNERAL DIRECTOR. GIVE PAGE 68 TO THE MEDICAL EXAMINER. GIVE PAGE 69 TO THE FUNERAL DIRECTOR. GIVE PAGE 70 TO THE MEDICAL EXAMINER. GIVE PAGE 71 TO THE FUNERAL DIRECTOR. GIVE PAGE 72 TO THE MEDICAL EXAMINER. GIVE PAGE 73 TO THE FUNERAL DIRECTOR. GIVE PAGE 74 TO THE MEDICAL EXAMINER. GIVE PAGE 75 TO THE FUNERAL DIRECTOR. GIVE PAGE 76 TO THE MEDICAL EXAMINER. GIVE PAGE 77 TO THE FUNERAL DIRECTOR. GIVE PAGE 78 TO THE MEDICAL EXAMINER. GIVE PAGE 79 TO THE FUNERAL DIRECTOR. GIVE PAGE 80 TO THE MEDICAL EXAMINER. GIVE PAGE 81 TO THE FUNERAL DIRECTOR. GIVE PAGE 82 TO THE MEDICAL EXAMINER. GIVE PAGE 83 TO THE FUNERAL DIRECTOR. GIVE PAGE 84 TO THE MEDICAL EXAMINER. GIVE PAGE 85 TO THE FUNERAL DIRECTOR. GIVE PAGE 86 TO THE MEDICAL EXAMINER. GIVE PAGE 87 TO THE FUNERAL DIRECTOR. GIVE PAGE 88 TO THE MEDICAL EXAMINER. GIVE PAGE 89 TO THE FUNERAL DIRECTOR. GIVE PAGE 90 TO THE MEDICAL EXAMINER. GIVE PAGE 91 TO THE FUNERAL DIRECTOR. GIVE PAGE 92 TO THE MEDICAL EXAMINER. GIVE PAGE 93 TO THE FUNERAL DIRECTOR. GIVE PAGE 94 TO THE MEDICAL EXAMINER. GIVE PAGE 95 TO THE FUNERAL DIRECTOR. GIVE PAGE 96 TO THE MEDICAL EXAMINER. GIVE PAGE 97 TO THE FUNERAL DIRECTOR. GIVE PAGE 98 TO THE MEDICAL EXAMINER. GIVE PAGE 99 TO THE FUNERAL DIRECTOR. GIVE PAGE 100 TO THE MEDICAL EXAMINER.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08095	
1- FOR STATE REGISTRAR										7a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) <b>Kimberly Lee Ann Sisselberg</b>										MONTH <b>3</b> DAY <b>23</b> YEAR <b>1985</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>05</b> YEAR <b>84</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>4</b>		IF UNDER 1 YR. MONTHS <b>4</b> DAYS <b>19</b>		7b. HOUR <b>M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b>		2d. DATE PRONOUNCED DEAD MONTH <b>3</b> DAY <b>23</b> YEAR <b>1985</b>		2d. HOUR <b>2:18A</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1831 Lemmon Street, 21223</b>			
14. FATHER'S NAME FIRST <b>Lewis</b> MIDDLE <b>J.</b> LAST <b>Sisselberger IV</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Patricia</b> MIDDLE <b>L.</b> LAST <b>Pyles</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>N/A</b>				16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Marie Thomas</b>		ADDRESS <b>641 Opel Road</b>		City <b>Glen Burnie, Md.</b> ZIP <b>21061</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8902</b> IMMEDIATE CAUSE (a) <b>Smoke and soot inhalation</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:58xx 3 22 1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>House fire</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET <b>1831 Lemmon St.</b> CITY OR TOWN <b>Balto.</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>3/23/85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>03-26-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		23d. LOCATION CITY OR TOWN <b>Baltimore City</b> COUNTY <b>Maryland</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b> ADDRESS <b>4107 Wilkens Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

2408

088027



Items 18-22a 5/6/85 5/6/85 mth

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

082001 08096  
REG. NO.

082001

1. DECEASED NAME (TYPE OR PRINT) John Rudolph Sitz			2a. DATE KNOWN OF DEATH ESTIMATED 3-10 1985			2b. HOUR 9:21		
3. SEX Male	4. RACE White	5. DATE OF BIRTH Aug. 14, 1944	6. AGE (IN YEARS) 40 YRS.	7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD 3-10 1985			2d. HOUR 9:21
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 426 S. Stricker Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY General	
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME Rudolph		15. MOTHER'S MAIDEN NAME Anna Gatzke		17. INFORMANT Helen P. Wiecezonek 2915 New York Ave.,				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-38-9282		ADDRESS Balto., Md. 21227				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Drug overdose DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 3/10 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject ingested overdose of drugs			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 426 S. Stricker St. Balto. City, Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .								
ACTUAL SIGNATURE [Signature]			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 3-10-85		
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/13/1985		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Ph.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A. A. Co., Md.		
24. FUNERAL DIRECTOR NAME McCurly Funeral Homes				ADDRESS Balto., Md., 21225 237 E. Patapsco Ave.,		25a. DATE REC'D. BY REGISTRAR MAR 12 1985		25b. REGISTRAR'S SIGNATURE [Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE CLERK AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

02520



080028

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES W. SIX</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 18, 1985</b>		2b. HOUR <b>9:00 A</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 16, 1902</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2030 Swansea Road</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Estimator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bendix Radio</b>		13a. STATE <b>MD</b>		
13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>2030 Swansea Road, 21239</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles B. Six</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Wilhelmina Hahn</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>340 07 9943</b>		17. INFORMANT ADDRESS <b>C. Virginia Six, Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <b>7/9</b> 19 <b>80</b> to <b>3/18</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>2/5</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Edward M. Miller, MD</b>				22c. DATE SIGNED <b>3/18/85</b>		
22d. ADDRESS <b>11 E. Chase Street, Balto., MD</b>				22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/21/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		
23d. LOCATION CITY OR TOWN <b>Balto.,</b>		COUNTY <b>MD</b>		STATE		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Henry W. Jenkins &amp; Sons Co. 4905 York Road Balto., MD 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1985</b>		
				25b. REGISTRAR'S SIGNATURE <i>Robert J. ...</i>		

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



088033

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH RANDOLPH SLADE			2a. DATE OF DEATH MONTH DAY YEAR March 23, 1985		2b. HOUR 10:00 <i>ma</i>
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 5, 1897	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4404 Eastway		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Milliner	12b. KIND OF BUSINESS OR INDUSTRY Millinery	
13a. STATE MD			13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Walter R. Slade			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Martin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 34 7363	17. INFORMANT ADDRESS Alan Garfinkle, Balto., MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of bowel</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <i>19 80</i> to <i>23 March 85</i> , that (1) (we) lost <i>23 March 85</i> above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>James M. Sowa</i>		DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>25 March 85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James M. Sowa, MD			22e. ADDRESS 714 York Road, Balto., MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/26/85	23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Hickory, Harford, MD		
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212			25a. DATE REC'D. BY REGISTRAR MAR 26 1985	25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



088033



Dr. James M. Dowd, MD  
714 York Road, Balto., MD  
Funeral Home, Inc., Hickey, Hartford, MD  
Harry W. Jenkins & Son Co.  
York Road, Balto., MD 21212





077011

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>John m Small Sr.</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>9</b> YEAR <b>85</b>			2b. HOUR <b>4:10 AM</b>					
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>29</b> YEAR <b>1962</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>22</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		7. IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		9. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD					
11. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chauffeur</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>A.A.</b> 13c. CITY OR TOWN <b>Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12 Ballman Ct 21225</b>					
14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Grace</b> MIDDLE <b>Small</b> LAST <b>Small</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>213-108428</b>		17. INFORMANT ADDRESS <b>Myrtle Small - Same as 13e</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardio Pulmonary Arrest 2° to Hypoxia.**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

**(b) Hypoglycemia, Hyperkalemia; S/P MI, TIA**

DUE TO, OR AS A CONSEQUENCE OF

**(c) Absence of colon Hemochromatosis, Pneumonia**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. - 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>-</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>		21f. LOCATION STREET <b>-</b> CITY OR TOWN <b>-</b> COUNTY <b>-</b> STATE <b>-</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/8</b> 19 <b>85</b> to <b>3/9</b> 19 <b>85</b> that (I) (we) last saw the deceased alive on <b>3/8</b> 19 <b>85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Marie E. Rodriguez MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/9/1985</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marie E. Rodriguez MD</b>				22e. ADDRESS <b>3061 S Hanover St Balto MD 21230</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/12/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem</b>		23d. LOCATION CITY OR TOWN <b>Balto</b> COUNTY <b>====</b> STATE <b>Md</b>	
24. FUNERAL DIRECTOR <b>George J. Gonca 4001 Ritchie Hwy Balto Md</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Sheila Davidson-Randall</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with your local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND									
FOR CHARLES G. SMITH DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
REGISTRAR CERTIFICATE OF DEATH									
REG. NO. 8508100									
1. DECEASED NAME (TYPE OR PRINT) Charles G. Smith			2a. DATE OF DEATH MONTH DAY YEAR 3 4 85			2b. HOUR 11:30 AM			
3 SEX MALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 05 22 12		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
12. CITY OR TOWN OF DEATH BALTIMORE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MED. CNTR.				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		15. KIND OF BUSINESS OR INDUSTRY MANUFACTURE	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE 16b. CITY OR TOWN 16c. RESIDENCE MARYLAND BALTIMORE ROSEDALE					17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS / ZIP CODE 1318 PINE GROVE AVE. 21237		
19. FATHER'S NAME FIRST MIDDLE LAST CHARLES SMITH					20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOLLY ROWLENC				
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					21b. SOCIAL SECURITY NO. 216013133		21c. INFORMANT ADDRESS CLARA SMITH 1318 PINE GROVE AVE.		
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
23a. DATE OF OPERATION			23b. CONDITION FOR WHICH OPERATION WAS PERFORMED			24a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
26a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			26c. LOCATION STREET CITY OR TOWN COUNTY STATE			
27. I certify that (this hospital) attended the deceased from 3/3/85, 19 85, to 3/4, 19 85, that (I) <input checked="" type="checkbox"/> saw the deceased alive on 3/4, 19 85, and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.									
28. SIGNATURE Glenn Bolton					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		29. DATE SIGNED 3/4		
30. PHYSICIAN'S NAME (TYPE OR PRINT) Glenn Bolton					31. ADDRESS FRANCIS SCOTT KEY MED. CNTR. EASTERN AVE.				
32a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL			32b. DATE 3/7/85		32c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		32d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		
33. FUNERAL DIRECTOR (NAME) J. J. Howard					ADDRESS 1211 Chesapeake Ave.		34. DATE REC'D. BY REGISTRAR MAR 6 1985		
					35. REGISTRAR'S SIGNATURE Jana Davidson-Randall				

• *un*

BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

098086

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 0 1

REG. NO.

1. DECEASED NAME [TYPE OR PRINT] <b>ELSIE SMITH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/30/85</b>			2b. HOUR <b>8:30 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 18 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Janitor</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>3600 Belvedere Ave. 21215</b>			
13a. STATE <b>MD.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Adams</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan Price</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Margaret Abrams 1511 N. Hilton St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetic Nephropathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>03-15</b> 19 <b>85</b> to <b>03-30</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3-30</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Sissay Anoke</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-30-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SISSAY Anoke</b>			22e. ADDRESS <b>Lutheran Hospital</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4-4-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie Md.</b>		
24. FUNERAL DIRECTOR NAME <b>William C. Brown</b>			ADDRESS <b>1206-08 W. North Ave</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 2-1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Pandell</b>	

MEDICAL CERTIFICATION



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FRANCES		SMITH		2a. DATE OF DEATH		MARCH 13, 1985		2b. HOUR		2:09			
3. SEX		Female		4. RACE		Black		5. DATE OF BIRTH		03 24 1936		6. AGE (IN YEARS LAST BIRTHDAY)		48 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY?		USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		BALTIMORE CITY		MD.	
10. CITY OR TOWN OF DEATH		BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Domestic		12b. KIND OF BUSINESS OR INDUSTRY		Laundry-Dom	
13a. STATE		Md.		13b. COUNTY		Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE		1527 Fulton Ave 21217			
14. FATHER'S NAME		Jesse Lee		15. MOTHER'S MAIDEN NAME		Florence Williams		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO				16b. SOCIAL SECURITY NO.		212-34-5678		Florence Smith		1109 Calhoun Rd					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		cardiopulmonary arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		40 min					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF		(b) Electromechanical dissociation		45 min							
				DUE TO, OR AS A CONSEQUENCE OF		(c) Myocardial infarct		2 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11c.															
19a. DATE OF OPERATION		None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
						P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from 3/11/85, 19 85, to 3/13, 19 85, that (I) (we) lost															
22b. SIGNATURE		Stuart R Fritz		DEGREE		MD		22c. DATE SIGNED		3/13/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		STUART R FRITZ		22e. ADDRESS		Johns Hopkins Hos		BALT, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		3-16-85		23c. NAME OF CEMETERY OR CREMATORY		Arbutus		23d. LOCATION		Baltimore Md.	
24. FUNERAL DIRECTOR		James A. Morton		ADDRESS		1701 Laurens St		25a. DATE REC'D. BY REGISTRAR		MAR 13 1985		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours of death and returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Copyright

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GLORIA L. SMITH</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>85</b>			2b. HOUR <b>600</b> <b>A</b> M					
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>30</b> YEAR <b>1935</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Saint Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howe</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8625 Old Annapolis Rd. Columbia, Maryland 21045</b>			
14. FATHER'S NAME FIRST <b>David</b> MIDDLE <b></b> LAST <b>Robinson</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Rebecca</b> MIDDLE <b></b> LAST <b>Patterson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>213-34-5437</b>		17. INFORMANT <b>Mr. Harold Smith</b> ADDRESS <b>8625 Old Annapolis Road Columbia, Maryland 21045</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCT</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>TEARS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ACUTE BRONCHOPNEUMONIA ACUTE POSTERIOR MEDIASTINITIS</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>2/25/85</b> , 19 <b>85</b> , to <b>3/5</b> , 19 <b>85</b> , that (we) lost saw the deceased alive on <b>3/5</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Steven H. Pearlman</b>						DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3/5/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEVEN H. PEARLMAN</b>						22e. ADDRESS <b>900 S. CATON AVE. BALTO MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/8/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>			23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE			
24. FUNERAL DIRECTOR'S NAME <b>Mutter &amp; Sons</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 6 1985</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		
Funeral Home Inc. Baltimore, Maryland 21216											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

Baltimore, Maryland

078057

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HERBERT L. SMITH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 16, 1985</b>		2b. HOUR P <b>11:10</b> M				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-11-35</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dept. of Agriculture U.S. Govt.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>West Va.</b>		13b. COUNTY <b>Dunbar</b>		13c. CITY OR TOWN <b>Dunbar</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Pierce B. Smith</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie C. Umberger</b>		16. STREET ADDRESS / ZIP CODE <b>211 Grandview Point - 25064</b>					

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-30-6250</b>		17. INFORMANT ADDRESS <b>Mrs. Nancy N. Smith 211 Grandview Point Dunbar West Va. - 25064</b>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>progressive hypoxia + hypotension</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>diffuse interstitial infiltrates of unknown etiology</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>autologous bone marrow transplant for</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2d</b> <b>10d</b> <b>1 month.</b>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  
**chronic myelogenous leukemia in blast crisis**

19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>—</b> <b>—</b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>—</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>			

22a. I certify that (I) (this hospital) attended the deceased from **2-28-85**, 19**85**, to **3/16**, 19**85**, that (I) (we) lost  
saw the deceased alive on **3/16**, 19**85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE <b>Patryce A. Toye, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/16/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PATRYCE A. TOYE, MD</b>		22e. ADDRESS <b>600 N. WOLFE ST. BALTO. MD. JOHNS HOPKINS HOSPITAL 21205</b>			

23a. BURIAL, CREMATION, REMOVAL (SPEC) <b>Burial</b>		23b. DATE <b>3-20-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sherwood Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pocono Virginia</b>	
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24. FUNERAL DIRECTOR NAME ADDRESS <b>John C. Miller Inc-6415 Belair Rd.-21206</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Gina Davidson-Randall</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified immediately.

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082004

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

08105

1. DECEASED NAME (TYPE OR PRINT) IDA M. SMITH			2a. DATE OF DEATH MONTH DAY YEAR 3 4 85			2b. HOUR 330 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 12 07		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Lett's Rest.	
13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Edward Brinton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Pearce			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 188-07-1634			17. INFORMANT ADDRESS Doris Treff 4000 Ridgcroft Rd. 21206						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) POSSIBLE TRACHEO ESOPHAGEAL FISTULA DUE TO, OR AS A CONSEQUENCE OF (c) MASSIVE MI REQUIRING MECHANICAL VENTILATION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HRS 3 DAYS 9 DAYS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE, ARDS									
19a. DATE OF OPERATION 2/28/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHEOSTOMY				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from 2/22/85, to 3/4/85, that (I) (we) last saw the deceased alive on 3/4/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Keith J. Schrader				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/4/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. KEITH J. SCHRADER				22e. ADDRESS UNION MEMORIAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-7-85		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home				25a. DATE REC'D. BY REGISTRAR MAR 07 1985		25b. REGISTRAR'S SIGNATURE Julia ...			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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093011

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JANNIE E. Smith</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>27</b> YEAR <b>85</b>			2b. HOUR <b>6:30 P.M.</b>	
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>12</b> YEAR <b>27</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Tom</b> MIDDLE LAST <b>Thomas</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Cora</b> MIDDLE LAST <b>?</b>		13e. STREET ADDRESS <b>21218 1003 Bonaparte Avenue</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>244-68-6410</b>		17. INFORMANT ADDRESS <b>James O. Smith 1003 Bonaparte Avenue</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cerebral Lobar Hemorrhage**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**4 days**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Metastatic Melanoma**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3-24</b> , 19 <b>85</b> , to <b>3-27</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3-27</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							

22b. SIGNATURE **Constance J. Meyd MD** DEGREE  
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐22c. DATE SIGNED  
**3-27-85**22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
**Constance J. Meyd**22e. ADDRESS  
**Francis Scott Key Hospital**23a. BURIAL, CREMATION, REMOVAL  
**BURIAL**23b. DATE  
**4/1/85**23c. NAME OF CEMETERY OR CREMATORY  
**Cedar Hill Cemetery Anne Arundel Co., Md.**24. FUNERAL DIRECTOR  
NAME **Wm C March F/H Inc. 1101 E North Avenue** ADDRESS25a. DATE REC'D. BY REGISTRAR  
**MAR 29 1985**25b. REGISTRAR'S SIGNATURE  
**Lelia Davidson-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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NO. 110000





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 & 4 should be detached for use as the burial-transit permit. Then please remove carbon-copy papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHAM - 16 50M 4/83  
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Levie				I.	Smith	March	18	1985	M
3. SEX		4. RACE		5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male		White		1910 MONTH DAY YEAR Sept. 18 1985	74 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
N. C.		U.S.A.				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Good Samaritan Hospital				Lift Operator		American	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5800 Walter Ave. 21236	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Marshall Smith				FIRST MIDDLE LAST Elizabeth Lizzie Hollway					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no		243-18-5436-A		Sue Wellslager		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>stroke</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>complete heart block = pacemaker placement</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>no meningioma - removed 5 years ago</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/12</u> , 19 <u>85</u> , to <u>3/13</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/13</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		22c. DATE SIGNED			
<u>Joseph R. Libertó, M.D.</u>				MD		3/19/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Joseph R. Libertó, M.D.				3501 Bank St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		3-22-85		Smith Plot on Clay Road		Ayden N.C.			
24. FUNERAL DIRECTOR				25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc				5305 Harford Rd.		MAR 20 1985			
						New Davidson-Randall			



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use in the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>RICHARD E SMITH</i>			2a. DATE OF DEATH MONTH <i>3</i> DAY <i>24</i> YEAR <i>85</i>			2b. HOUR <i>8:30</i> P M					
1. SEX <i>MALE</i>		4. RACE <i>BLACK</i>		5. DATE OF BIRTH MONTH <i>8</i> DAY <i>31</i> YEAR <i>40</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>44</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS HOURS <i></i> MIN. <i></i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE MD</i> MD.					
10. CITY OR TOWN OF DEATH <i>CITY</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>LUTHERAN HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Bond distributing</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Bottling Co.</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE <i>3304 WANDOR AVE 21216</i>			
13a. STATE <i>MD</i>		13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>BALTIMORE</i>							

14. FATHER'S NAME FIRST <i>Arthur</i> MIDDLE <i>A.</i> LAST <i>Smith</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Louise</i> MIDDLE <i></i> LAST <i>Harris</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>219-38-3140</i>		17. INFORMANT <i>Lutheran Hosp.</i>		ADDRESS <i>730 Capital Hill St.</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolus</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Venothrombosis @ leg</i>			
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION <i>3/23</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i></i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/23</i> <i>85</i> , to <i>3/24</i> <i>85</i> , that (I) (we) lost saw the deceased alive on <i>3/24</i> <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Bach T Duong</i>				DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>3/24/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BACH T DUONG</i>				22e. ADDRESS <i>LUTHERAN HOSPITAL</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/25/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Western Star Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Bailey-Douglass</i> ADDRESS <i>1348 Calhoun St</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 27 1985</i>			
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH KNOWN OF ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR	
ROBERT LEE SMITH								XX 3		4		19		85		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	6 8 31		53		YRS.				3 5		19		85		8:28P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
VA		USA										BALTIMORE		CITY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		2109 Baker Street															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2109 Baker St. 21217									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST				FIRST MIDDLE LAST													
Winston Smith																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS									
Yes				226-34-6239				Lorriane White 2109 Baker St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
DIABETES MELLITUS																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
TITLE (SPECIFY)																	
ACTUAL SIGNATURE				M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED					
Dennis F. Smyth, M.D.				111 Penn Street, Balto, MD 21201				Mar 6, 1985									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				3/11/85		Garrison Forest VA				Owings Mills MD							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Wm. C. March F/H				1101 E. North Ave.				MAR 7 1985				[Signature]					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
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DHMH - 17  
(VR A15 ME (5))



082005

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
Roul C. Smith		3/4/85		11:45 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	Black	MONTH DAY YEAR	72 YRS	Baltimore, MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
S.C.	U.S.A.		Clergyman		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	XXXXXX 704 N. Gilmore St.		--0----		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland		none	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	704 N. Gilmore St. 21217
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Riley Smith		Sarah Smith		(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
251-05-0332		Lucille Smith, 704 N. Gilmore Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>End Terminal heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic, advanced Interstitial lung disease - years</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>none</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN/23</u> 19 <u>85</u> , to <u>2/23</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>2/23</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Dr. [Signature]</u>		22c. DATE SIGNED <u>3/7/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
MARCEUS E. ALKRENE		1940 W. Balt St Balto Md 21203			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		March 11, 85	Maryland Nat Park		Laural Md
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Law Funeral Home 4611 Park Heights Ave. 21215		MAR 12 1985		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Charles D Donald Smithson, Sr. <i>Charles D Smithson</i>			2a. DATE OF DEATH MONTH DAY YEAR 3 18 85		2b. HOUR 5:30 AM
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 11 19	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) XMDUSA MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY retired
13a. USUAL RESIDENCE (IF HAVING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13a. COUNTY Kent		13c. CITY OR TOWN Rock Hall	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE PO Box 233 Rock Hall MD 21661
14. FATHER'S NAME FIRST Charles F. MIDDLE LAST Jr.		15. MOTHER'S MAIDEN NAME FIRST Dorothy T. MIDDLE LAST Lewis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 217 036226		17. INFORMANT Rock Hall, MD 21661 Ethel Smithson, P. O. Box 233	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ventilator dependence</u>					
19a. DATE OF OPERATION 1/11/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Stenosis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>3/1</u> 19 <u>85</u> , to <u>3/18</u> 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>3/18</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)					
22b. SIGNATURE <i>Robert M.D.</i>		DEGREE		22c. DATE SIGNED 3/18/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER PEARL JR		22e. ADDRESS University Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 03/21/85		23c. NAME OF CEMETERY OR CREMATORY St. John's Church Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall Kent MD		24. FUNERAL DIRECTOR NAME ADDRESS Tom Helfenbein Funeral Homes, Chester, MD 21619			
25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE <i>W. J. Harrison-Randall</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use at the funeral home permit. Then please return carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)

FIRST MIDDLE LAST

2a. DATE KNOWN OF DEATH

MONTH DAY YEAR

2b. HOUR

3. SEX

4. RACE

5. DATE OF BIRTH

MONTH DAY YEAR

6. AGE (IN YEARS LAST BIRTHDAY)

7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED NEVER MARRIED WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LIVING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

14. FATHER'S NAME

15. MOTHER'S MAIDEN NAME

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT

17. ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

21g. CITY OR TOWN

21h. COUNTY

21i. STATE

22. I certify that I took charge of the remains described above, held on death resulted from

Autopsy

Inspection

Inquiry

and in my opinion

Natural cause

Accident

Suicide

Homicide

Undetermined manner

ACTUAL SIGNATURE

TITLE (SPECIFY)

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S NAME (TYPE OR PRINT)

ADDRESS

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

20 July 1907



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Steve J. Sollon			2a. DATE OF DEATH MONTH DAY YEAR 3 7 85		2b. HOUR 5 <sup>00</sup> P.M.
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 6 21 21	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY economist/painter	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore City Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James NMI Sollon			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA NMI GRAKAFOS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW#? 8214 206934	17. INFORMANT ADDRESS chart		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>pneumonia</u>					
19a. DATE OF OPERATION 0		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/23/85</u> , 19 <u>85</u> , to <u>3/7</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/7</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.					
22b. SIGNATURE <u>Barbara A. Conley</u>		DEGREE MD		22c. DATE SIGNED 3/7/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARBARA A. CONLEY MD		22e. ADDRESS UMCC 225. Greene St. Balto Md 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 03/11/85		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		24. FUNERAL DIRECTOR Connelly Funeral Home of Dundalk ADDRESS			
25a. DATE REC'D. BY REGISTRAR MAR 13 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON CIBERON  
DAILY WASH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 17

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Simon Solorzano</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 15, 1985</b>		2b. HOUR <b>4:05A</b> M	
3. SEX <b>Male</b>		4. RACE <b>Mexican</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 8 26</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Federico Solorzano</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>457-20-4919</b>		17. INFORMANT ADDRESS <b>Addie Mae Solorzano 1138 Argyle Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>End Stage Liver failure</b> DUE TO, OR AS A CONSEQUENCE OF: (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Multiple Decubiti</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (X) (this hospital) attended the deceased from <b>March 7</b> , 19 <b>85</b> , to <b>March 15</b> , 19 <b>85</b> , that (X) (we) lost above, the deceased alive on <b>March 15</b> , 19 <b>85</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>M Shaukat</b>		DEGREE <b>MB BS</b>		22c. DATE SIGNED <b>3/15/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M SHAUKAT M.D. B.S.</b>		22e. ADDRESS <b>c/o Maryland General Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3/18/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Pk.</b>		
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>		
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



4:4

March 11, 1917

Dear Sir:

Dear Sir:

Very truly yours,

W. H. C. [illegible]

W. H. C. [illegible]



W. H. C. [illegible]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
PAUL Henry SOURS					MARCH 29, 1985				12:36
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
male	white	October 27, 1908			76	MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia	U.S.A.				BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE	JOHNS HOPKINS HOSPITAL			supervisor		air craft			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. STREET ADDRESS / ZIP CODE				
13a. STATE CITY COUNTY Maryland Washington Hagerstown					13b. 106 Day Road 21740				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Hubert Franklin Sours					FIRST MIDDLE LAST Mary Catherine Shirey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no		228-01-0835		Mrs. Dorothy M. Sours, Hagerstown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CARDIAC ARREST									1 hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									4 days
(b) CONGESTIVE HEART FAILURE									
(c) AORTIC STENOSIS									YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/17, 19 85, to 3/29, 19 85, that (I) (we) last saw the deceased alive on 3/29, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas Chambers					DEGREE MD			22c. DATE SIGNED 3/29/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS CHAMBERS					22e. ADDRESS JOHNS HOPKINS HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
burial		April 2, 1985		Rest Haven Cemetery		Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland 21740					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
					APR 3 1985		[Signature]		

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 1 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph S. Sparra			2a. DATE OF DEATH MONTH DAY YEAR 3 20 85		2b. HOUR 155 AM	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 12 23 98		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN) Poland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen. Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY Motion Picture	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY Baltimore City	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph ----- Sparra		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary ----- UNK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) unk No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-07-3177		17. INFORMANT ADDRESS Pasadena, Md. Chart Mrs. Irene Airey, 8407 Echo Dr. 21122		
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Urinary Tract Obstruction Prostatic Ca</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.1a <u>Diabetes Mellitus, Congestive Heart Failure</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>March 17</u> , 19 <u>85</u> , to <u>March 20</u> , 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>March 20</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>R. Neufeld</u>		DEGREE <u>MD</u>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert J. Neufeld</u>		22e. ADDRESS <u>South Baltimore Gen. Hosp.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Mar. 23, 1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>		
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Co. Maryland</u>		23e. DATE REC'D. BY REGISTRAR <u>MAR 21 1985</u>				
24. FUNERAL DIRECTOR <u>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</u>						

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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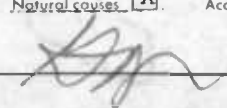

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

08117

1. DECEASED NAME (TYPE OR PRINT) <b>Lisa L. Dunlap Spence</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3/12/1985</b>		2b. HOUR <b>7:48</b>	
1. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 19 58</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>26</b> YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Allen Harper</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Doris Harper</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>219-66-5816</b>		17. INFORMANT ADDRESS <b>Doris Harper 2064 Kennedy Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intravenous Narcotism</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a.									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>3/12/85</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>				ADDRESS <b>111 Penn St.</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3/16/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Pk</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b>				ADDRESS <b>1101 E North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1985</b>	
25b. REGISTRAR'S SIGNATURE 									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))

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WINTER



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 08118

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WALTER R. SPENCER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 3 12 1985</b>		2b. HOUR <b>1:18A</b> M
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 11, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, BALTIMORE, MD. 21218</b>		12a. USUAL OCCUPATION (IF DECEASED IN SERVICE OR BUSINESS, GIVE SERVICE OR BUSINESS) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. STREET ADDRESS / ZIP CODE <b>869 W. Fayette St. 21201</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter R. Spenser</b>		15. MOTHER'S MAIDEN NAME MIDDLE LAST <b>Bessie Burges</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>WW#2 218093616</b>		17. INFORMANT ADDRESS <b>Alma Spencer/869 W. Fayette St.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) GI hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

(c) End stage liver diseaseAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>2/21</u> , 19 <u>85</u> , to <u>3/12</u> , 19 <u>85</u> , that (we) last saw the deceased alive on <u>3/12</u> , 19 <u>85</u> , and that (we) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (not) view the body after death.			
22b. SIGNATURE <u>D. Schamp MD</u>		22c. DATE SIGNED <u>3/12/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D. Schamp MD</u>		22e. ADDRESS <u>3900 LOCH RAVEN BLVD. BALTO. MD. 21218</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/18/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest VA</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Owings Mill (Balto) Md.</b>
24. FUNERAL DIRECTOR <b>Marshall W. Jones, Jr/4101 Edmondson Ave</b>		25a. DATE REC'D. BY REGISTRAR (RECORD DATE) <b>MAR 20 1985</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 5 0 8 1 1 9	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>ROSE M Spinoso</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 22 85</i>		2b. HOUR <i>10<sup>00</sup> P.M.</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>6-12-1920</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Good Samaritan Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Maker</i>	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13a. STATE <i>Md.</i>	13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>Balto.</i>	13e. STREET ADDRESS <i>1313 Glendale Rd. - 21239</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas Marcino</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Amelia</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-09-3529</i>	17. INFORMANT ADDRESS <i>Mr. John V. Spinoso - 1313 Glendale Rd. 21239</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>yes</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>1976</i> , 19____, to <i>3/22/85</i> , 19____, that (1) (we) last saw the deceased alive on <i>3/15/85</i> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>C. John Miller</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/24/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Folkemer</i>		22e. ADDRESS <i>MERCY Hosp. Vol.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-25-85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>
24. FUNERAL DIRECTOR <i>John C. Miller Inc-6415 Belair Rd. - 21206</i>			25. DATE REC'D. BY REGISTRAR 18. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>		

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Baltimore	John	191-1-121	John
John	John	191-1-121	John
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John . . . . . 191-1-121

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>NORMAN M. SPRIGGS</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3/18/85</i>			7b. HOUR <i>8:15 A</i>	
3. SEX <i>M</i>		4. RACE <i>B</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10-31-25</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>59</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Kukheran Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>unemployed</i>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>135 Maryland</i>					
13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>103 N. Wood Ave. 21217</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Norman W. Spriggs</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lena Henson</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-20-6474</i>		17. INFORMANT ADDRESS <i>Hilda Spriggs 1117 N. Fulton Ave.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>S.P. resp. failure 2° bilateral pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>chronic alcohol abuse</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2/12/85</i> <i>2/15/85</i> <i>4K</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>supra ventricular tachycardia</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/12</i> , 19 <i>85</i> , to <i>3/18</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3/18</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. Matun N. Naeem</i>				DEGREE <i>MD</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR. MATUN N. NAEEM</i>				22e. ADDRESS <i>501 Dolphin Street Baltimore MD 21217</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/21/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>mt. Auburn Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. mo</i>	
24. FUNERAL DIRECTOR NAME <i>Wm. C. March E/H</i>				ADDRESS <i>1101 E. North Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 20 1985</i>	
				25b. REGISTRAR'S SIGNATURE <i>William A. Hendell</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, B should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



085005

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN DEWEY SQUIRE			2a. DATE OF DEATH MONTH DAY YEAR 3/11/85			2b. HOUR 2:20A M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 05 10 08		6. AGE (IN YEARS LAST BIRTHDAY) 76		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sanitation Worker Balto. City		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3018 Presstman St. Baltimore, Maryland 21216	
14. FATHER'S NAME FIRST MIDDLE LAST John Squire				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Squire					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No.		16b. SOCIAL SECURITY NO. 217-09-1748		17. INFORMANT 3018 Presstman St. Mrs. Violet Squire Baltimore, Md. 21216					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> 19 <u>85</u> to <u>3/11</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/11</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L. C. CUTO</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/11/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LEONARD C. CUTO</u>				22e. ADDRESS <u>LUTHERAN HOSPITAL</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/16/1985		23c. NAME OF CEMETERY OR CREMATORY Gaston Baptist Ch. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Halifax Co., N. Carolina			
24. FUNERAL DIRECTOR'S NAME <u>Nutter &amp; Sons</u>				25a. DATE REC'D. BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			
25c. ADDRESS 2501 Gwynns Falls Parkway Funeral Home, Inc. Baltimore, Maryland 21216									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Sanitation Service, City  
John Davidson  
St. Albans, Vermont

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Sanitation Service, City

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DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 2 2

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) VERONICA R. STACHOWSKI			2a DATE OF DEATH MONTH DAY YEAR MARCH 24, 1985		2b HOUR 4:31 PM
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 5 20 1903		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD.		13b COUNTY	13c CITY OR TOWN BALTIMORE	13d STREET ADDRESS / ZIP CODE 526 S. LAKEWOOD AVE 21220	
14 FATHER'S NAME FIRST MIDDLE LAST AUGUSTINE NOWAK		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE PASEKA			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS RONALD STACHOWSKI 607 S. KENWOOD AVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NECROTIZING FASCIITIS DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: A.S.C.V.D. AND PERIPHERAL VASCULAR DISEASE.					
19a DATE OF OPERATION MARCH 21, 1985		19b CONDITION FOR WHICH OPERATION WAS PERFORMED TISSUE TO REMOVE AND DEBRIDE INFECTIOUS		20a AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) this hospital attended the deceased from MARCH 19, 19 85, to MARCH 24, 19 85, that (I) I lost saw the deceased alive on MARCH 24, 19 85, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b SIGNATURE L. K. Peredo M.D.		DEGREE		22c MEDICAL PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) LUZVIMINDA K. PEREDO M.D.		22e ADDRESS CHURCH HOSPITAL CORPORATION 100 NORTH BROADWAY BALTO., MD. 21231			
23a BURIAL, CREMATION, REMOVAL BURIAL		23b DATE 3/28/1985		23c NAME OF CEMETERY OR CREMATORY Holy ROSARY	
23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD		24 FUNERAL DIRECTOR NAME ADDRESS RAYMOND H. KACZOROWSKI 2525 FLEET ST.			
25a DATE REC'D. BY REGISTRAR MAR 26 1985		25b REGISTRAR'S SIGNATURE John Bairden			

MEDICAL CERTIFICATION



082020



082020

082020





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

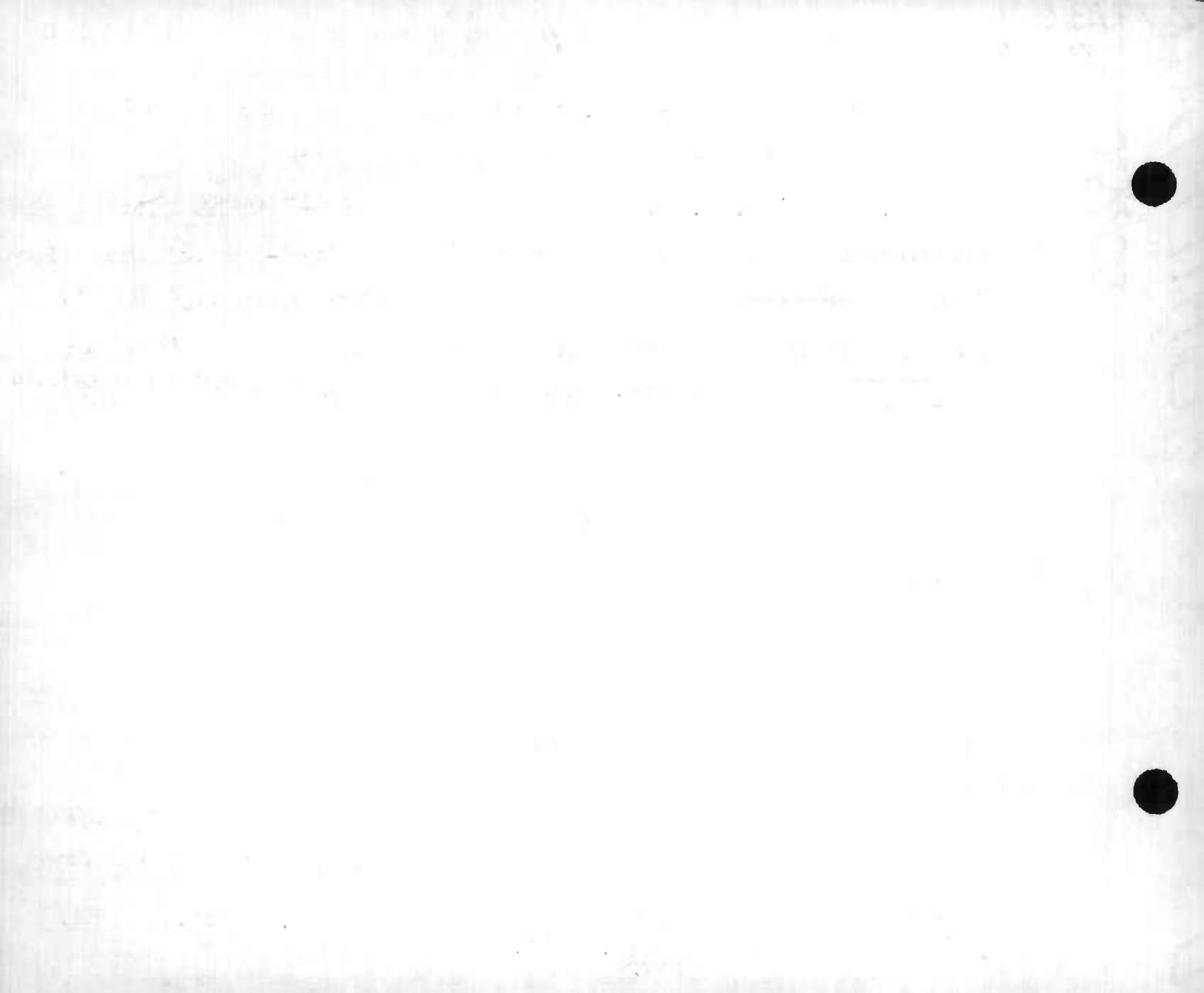
8 5 0 8 1 2 3

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Henry Lawrence Stafford			2a. DATE OF DEATH MONTH DAY YEAR 03 16 85			2b. HOUR M					
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 07 07 01		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Dept. of Education			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5109 Balto. Nat'l. Pike #A3 21229		
14. FATHER'S NAME FIRST MIDDLE LAST David McPherson Stafford			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Elizabeth Magliet								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-09-6937			17. INFORMANT Ruth Elizabeth Stafford			ADDRESS 5109 Balto. Nat'l. Pike 21229		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>possible staph pneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Diabetes mellitus</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/9</u> 19 <u>85</u> , to <u>3/16</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/16</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/16/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marcelino D. Albuera MD			22e. ADDRESS 2506 Lexington Balto Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 19, 1985			23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24. FUNERAL DIRECTOR G. Truman Schwab			ADDRESS 5151 Balto. Nat'l. Pike			25a. DATE REC'D BY REGISTRAR MAR 18 1985			25b. REGISTRAR'S SIGNATURE R. Anderson-Rendell		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 2 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEO OTTO STAMM SR.		2a. DATE OF DEATH MONTH DAY YEAR 3 9 85		2b. HOUR 12:02A M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 02 25 26		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MEDICAL CTR.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHAUFFEUR		12b. KIND OF BUSINESS OR INDUSTRY TRUCKING
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN DUNDALK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH S. STAMM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN MILES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II		16b. SOCIAL SECURITY NO. 219-16-9108		17. INFORMANT ADDRESS FRANK T. THURSTON 1 1/2 UNIVERSITY AVE., 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>February 17</u> , 19 <u>85</u> , to <u>March 9</u> , 19 <u>85</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>March 9</u> , 19 <u>85</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.					
22b. SIGNATURE <u>Robert Fisher</u>		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Fisher		22e. ADDRESS 4940 Eastern Ave. Baltimore, MD 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 03-12-85		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.	
23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229			
25a. DATE REC'D. BY REGISTRAR MAR 11 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

BP \_\_\_\_\_

027002

937 NORTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

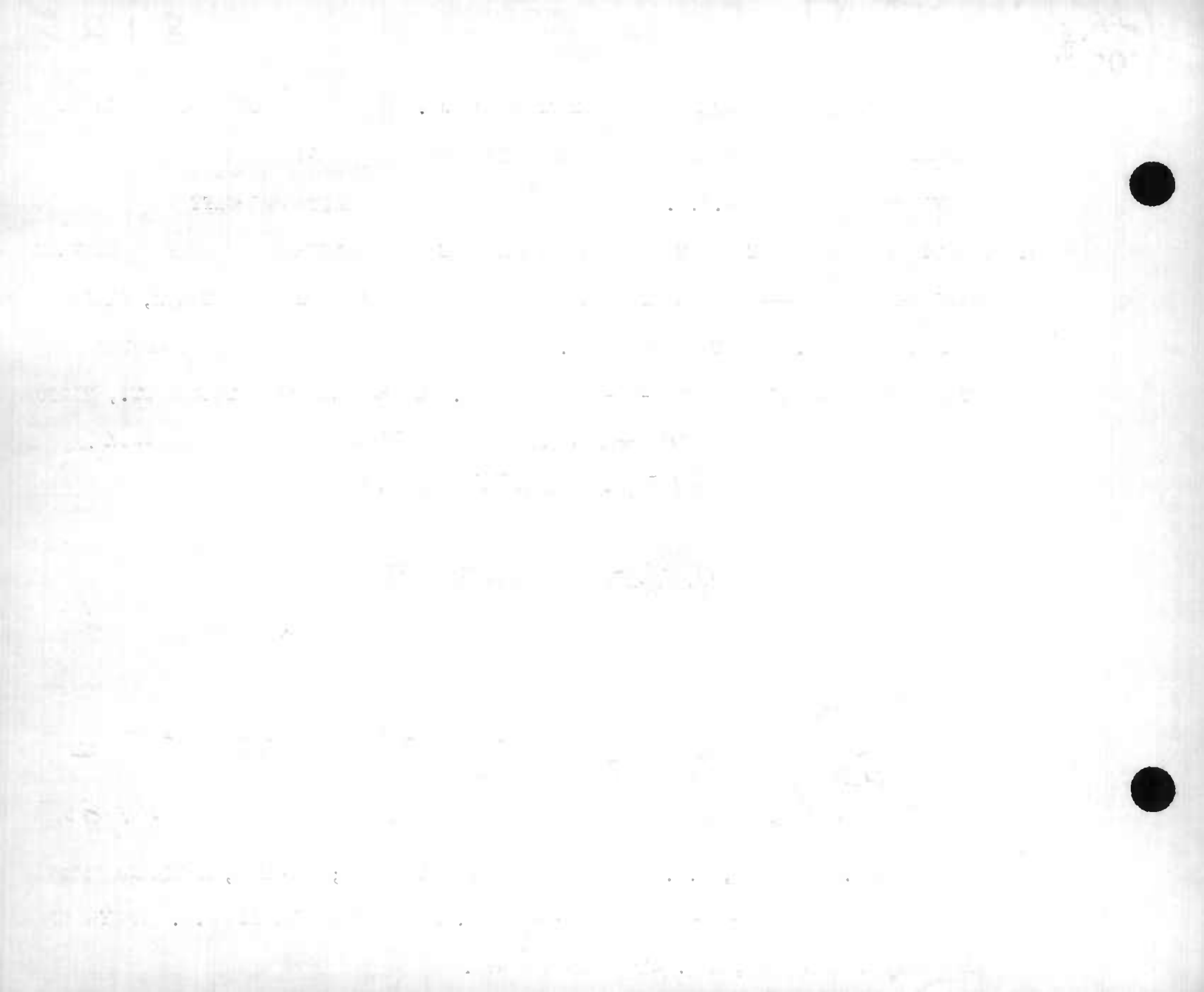
8508125

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN FREDERICK STEINACKER JR.			2a. DATE OF DEATH MONTH DAY YEAR 03 09 85			2b. HOUR 1:50P M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 03 16 18		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY FOOD BROKERS	
13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2309 TACOMA STREET, 21230	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN F. STEINACKER SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE FOERSTER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ANNA I. STEINACKER		ADDRESS 2309 TACOMA ST., 21230			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic CVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes Mellitus, II</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (s) (this hospital) attended the deceased from <u>1/8</u> , 19 <u>80</u> , to <u>3/9</u> , 19 <u>85</u> , that (s) (we) last saw the deceased alive on <u>3/1</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Herbert J. Levickas, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/11/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HERBERT J. LEVICKAS, M.D.				22e. ADDRESS 5404 EAST DRIVE, ARBUTUS, MARYLAND 21227					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 03-12-85		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR MAR 12 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	


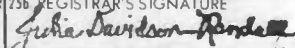
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082009

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>NATHANIEL STEPTER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 3, 1985</b>		2b. HOUR <b>2:06 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 2 1902</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS) <b>Church Home Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laundry Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Vet. hospital</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Moses William Stepter</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan Payne</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>AW 11</b>	17. INFORMANT ADDRESS <b>Clara Payne 11 W. 20th St. Apt. 16C</b>		
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last. (b) <b>PROBABLY ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HISTORY OF PERIPHERAL VASCULAR DISEASE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <b>MARCH 2</b> , 19 <b>85</b> , to <b>MARCH 3</b> , 19 <b>85</b> , that (2) (we) last saw the deceased alive on <b>MARCH 3</b> , 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death.					
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>MAR 3, 1985</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MUKESH LUHAR</b>		22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MD 21231</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3-8-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Owings Mill Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Bailey Douglas 1348 Calhoun St</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1985</b>		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

29

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DHMH - 16 60M 7/B4  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REBILITATION - 30%

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 2 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lillian Le Stern			2a. DATE OF DEATH MONTH DAY YEAR 3/17/85			2b. HOUR 8:15 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 2 1889		6. AGE (IN YEARS LAST BIRTHDAY) 85		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. MD.			
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13e. STREET ADDRESS / ZIP CODE 4211 Belview Ave 21215			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT Eleanor Ashley 4211 Belview Ave 21215				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic &amp; infected pressure ulcers</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Demented &amp; chronic brain syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 24</u> 19 <u>84</u> , to <u>March 17</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive or above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J.W. Reed M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/18/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.W. Reed			22e. ADDRESS 6115 CHAS. ST. BALTO. MD. 21230						
23a. BURIAL, CREMATION, REMOVAL (CIFY) Cremation			23b. DATE 3-19-85		23c. NAME OF CEMETERY OR CREMATORY Westview Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24. FUNERAL DIRECTOR NAME Leroy O. Syett 4600 Liberty Hgts Ave			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE MAR 19 1985			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

11/11/10

Handwritten notes and scribbles at the top of the page, including a large 'X' and some illegible text.

Main body of handwritten text, appearing as faint, illegible scribbles across the lower half of the page.

094142

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

5/22/85 Item 13 L.J

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BABY CYNTHIA STEWART</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>3</b> YEAR <b>85</b>			2b. HOUR <b>1130 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>3</b> YEAR <b>85</b>		6. AGE [IN YEARS (LAST BIRTHDAY)] YRS <b>2</b> MONTHS <b>8</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY OF MARYLAND HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>2213 West Lanvale 21216</b>							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CYNTHIA STEWART</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>NON VIABLE FETUS : ABORTION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1015 PM, 3/3, 1985</b> , to <b>1130 PM 3/3 / 1985</b> , that (I) (we) last saw the deceased <b>with heart rate on 3/3 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Sanjiv Sur</b>		DEGREE <b>MD</b>		Resident ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/4/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SANJIV SUR</b>				22e. ADDRESS <b>2935 Guilford Ave, Baltimore, MD 21218</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>3/14/85</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>							

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REPAIR MOTION

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>BERNARD EDGAR STICKELL, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAR. 15, 1985</b>			2b. HOUR <b>8:53 AM</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Feb. 2, 1925</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>60</b>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>United States</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>			
10 CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self-employed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1431 Woodland Beach Rd./21122</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Allen F. Stickell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen - Schultz</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF SERVICE WAR OR DATES) <b>W.W. - 2 216-20-7840</b>		17. INFORMANT ADDRESS <b>Betty J. Stickell/1431 Woodland Beach Rd.</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYDCARDIAL INFARCT</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>-</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>-</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <b>March 10, 1985</b> to <b>March 15, 1985</b> , that (a) (we) lost saw the deceased alive on <b>March 15, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Bert F. Morton</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>3-15-85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERT F. MORTON</b>						22e. ADDRESS <b>St. Agnes Hospital/ Baltimore, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>3-18-1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process Inc.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonville, Baltimore Co., Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Mc Cully Funeral Home, Pasadena, Md. 21122</b>						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>MAR 21 1985 Julia Davidson-Randall</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

8 5 0 8 3 0

1- FOR  
STATE  
REGISTRAR

MARSHALL STINCHCOMB

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Marshall Stinchcomb</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 16, 1985</b>			2b. HOUR <b>3:05 AM</b>			
3. SEX <b>male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 11, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>laborer retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>10799 Hickory Ridge Rd. 21044</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Grover Stinchcomb</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Estelle Hill</b>			16. ADDRESS <b>9625 Basket Ring Road Columbia, Md. 21044</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW2</b>		16b. SOCIAL SECURITY NO. <b>274-14-7376</b>		17. INFORMANT <b>Deborah Brown</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Disseminated Intravascular coagulation</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Small cell undifferentiated carcinoma lung.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Peripheral Vascular disease. Hypertension</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1981</b> 19 <b>87</b> , to <b>Present</b> 19 _____, that (I) (we) lost saw the deceased alive on <b>3-16-</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Paul C. Charkowski</b> M.D.						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3-16-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SS Charkowski</b>						22e. ADDRESS <b>2 Knoll North Drive Columbia Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) <b>Burial</b>		23b. DATE <b>3/20/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Veterans</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Owings Mills Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A. 5555 Twin Knolls Rd., Columbia, Md. 21045</b>									
J. BY REGISTRAR REGISTRAR'S SIGNATURE <b>MAR 18 1985 Julia Davidson-Randall</b>									



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and retained by the hospital or attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 are to be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 3 is to be retained by the funeral director. IMPORTANT: If item 21 is marked as item 8, shows body injury, or other traumatic event, the medical examiner will be notified at once.

1-RELEASED AS NON-MED DR. KAUFFMAN PER MR. HENRY

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIE T. STOKES</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 9, 1985</b>			2b. HOUR <b>9:42</b> M		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 2 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (COUNTRY) <b>VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>					13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>2319 E. Preston St. 21213</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Willie T. Stokes Sr.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lottie Wright</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-07-1088</b>		17. INFORMANT ADDRESS <b>Florine C. Stokes 2319 E. Preston St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>lung cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>1 month</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>hypercalcemia, cervical spine fracture (pathological) NAK.</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/9</b> , 19 <b>85</b> , to <b>3/9</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Stephen C. Redd</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3/9/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen C. Redd</b>					22e. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL 600 N. Wolfe St. Baltimore, MD 21205</b>					
23a. BURIAL, CREMATION, REMOVAL (SEE 15V) <b>Burial</b>			23b. DATE <b>3/14/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 E. North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1985</b>				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
BENJAMIN Franklin		STONE						3 1 1985								12:01 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	10/23/06		78 YRS.						3 1 19 85							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Georgia		USA				Baltimore City											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		843 Power St.		U.S. ARMY Retired		Retired											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		843 Powers Street 21211									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
James Lenord Stone		Sally Margaret Stone															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		252 32 9920		Betty Atkinson		same											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Ann M. Dixon, M.D.		M.D. Assistant		3-1-85													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
		111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Cremation		03/04/85		Westview Crematory		Westview, Balto. Co. Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Burgee-Henss Funeral Home		3631 Falls Rd. 21211		MAR 6 1985		John Davidson-Randall											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

010020

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 3 3

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas H Stubbs			2a. DATE OF DEATH MONTH DAY YEAR 3 3 85		2b. HOUR 4 AM
3. SEX M	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 10 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 72 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pineblow N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.		
10. CITY OR TOWN OF DEATH Balto. City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Deaton MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK	12b. KIND OF BUSINESS OR INDUSTRY GROCERY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY HOWARD	13c. CITY OR TOWN ELLICOTT CITY	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT L STUBBS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE VICTORIA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-01-9228	17. INFORMANT ADDRESS DAUGHTER 9419 FAIRLEIGH COURT BURKE, VA 22015			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of R tonsil DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Myocardial infarction - ASCVD					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Feb 12, 19 85, to Mar 3, 19 85, that (I) (we) lost saw the deceased alive on Mar 3, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ron Wisz	DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 3/3/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ron Wisz		22e. ADDRESS Deaton Med Ctr Balto, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 3/7/85	23c. NAME OF CEMETERY OR CREMATORY FAIRFAX MEMORIAL PARK	23d. LOCATION CITY OR TOWN COUNTY STATE FAIRFAX VIRGINIA	24. FUNERAL DIRECTOR NAME ADDRESS DEMAINE FUNERAL HOMES, INC. ALEXANDRIA, VIRGINIA	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		REG. NO.		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
PAUL THOMAS STURGILL										3-17-85						19		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d. HOUR	
Male		White		June 4 1962		22						3-17-85						19		8:29P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		X NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH								MD.	
Md.		USA										Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore		2218 Westfield Avenue		Construction																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Md.				Baltimore		YES X NO		6210 Plymouth Road													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
Thomas D. Sturgill		Rita C. Keen Smith																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
yes		214-84-0586		Mrs. Mary Allison Sturgill		Same															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) Gunshot wound of chest																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b)																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 DTNED SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																	
				YES X NO																	
21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																	
		15:43 PM 3/17/85		self-inflicted																	
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK X		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION																	
		house		2218 Westfield Avenue Baltimore, Maryland																	
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy XX Inspection Inquiry and in my opinion																			
Natural causes Accident Suicide X Homicide Undetermined manner																					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE																	
Margarita A. Korell, M.D.		Assistant		3-18-85																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																			
111 Penn Street																					
23a. BURIAL, CREMATION, REMOVAL (CHECK BY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION															
Burial		Mar. 20, 1985		New Cathedral		Baltimore															
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Leonard J. Ruck Inc. Baltimore, Maryland		MAR 20 1985		[Signature]								</									

BP\_\_\_\_\_

DHMH - 17

(VR A15 ME (5))

NOTICE

MAR 20 1952



MAR 20 1952



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# 2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8135

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>EDNA SULLIVAN</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3/5/85</i>		2b. HOUR <i>5:55 PM</i>						
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>05 10 27</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>57 YRS.</i>		7. IF UNDER 1 YEAR MONTHS DAYS <i>57</i>		8. IF UNDER 24 HRS HOURS MIN. <i>57</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Easton, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City MD.</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>John C. Deaton Medical Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>827 Arlington Ave 21217</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Edward Sullivan</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sarah Sullivan</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>2</i>		17. INFORMANT NAME ADDRESS <i>Cathyn Wallace</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Esophageal cancer</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>2/1/85</i> 19 <i>85</i> , to <i>3/5</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3/5</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Ron Wish</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>3/6/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ron Wish</i>			22e. ADDRESS <i>Deaton Med Cntr Balt</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>3/9/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Richardson</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Easton MD</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>George H. Deshield</i>			25a. DATE REC'D. BY REGISTRAR <i>MAR 14 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i>					

MEDICAL CERTIFICATION

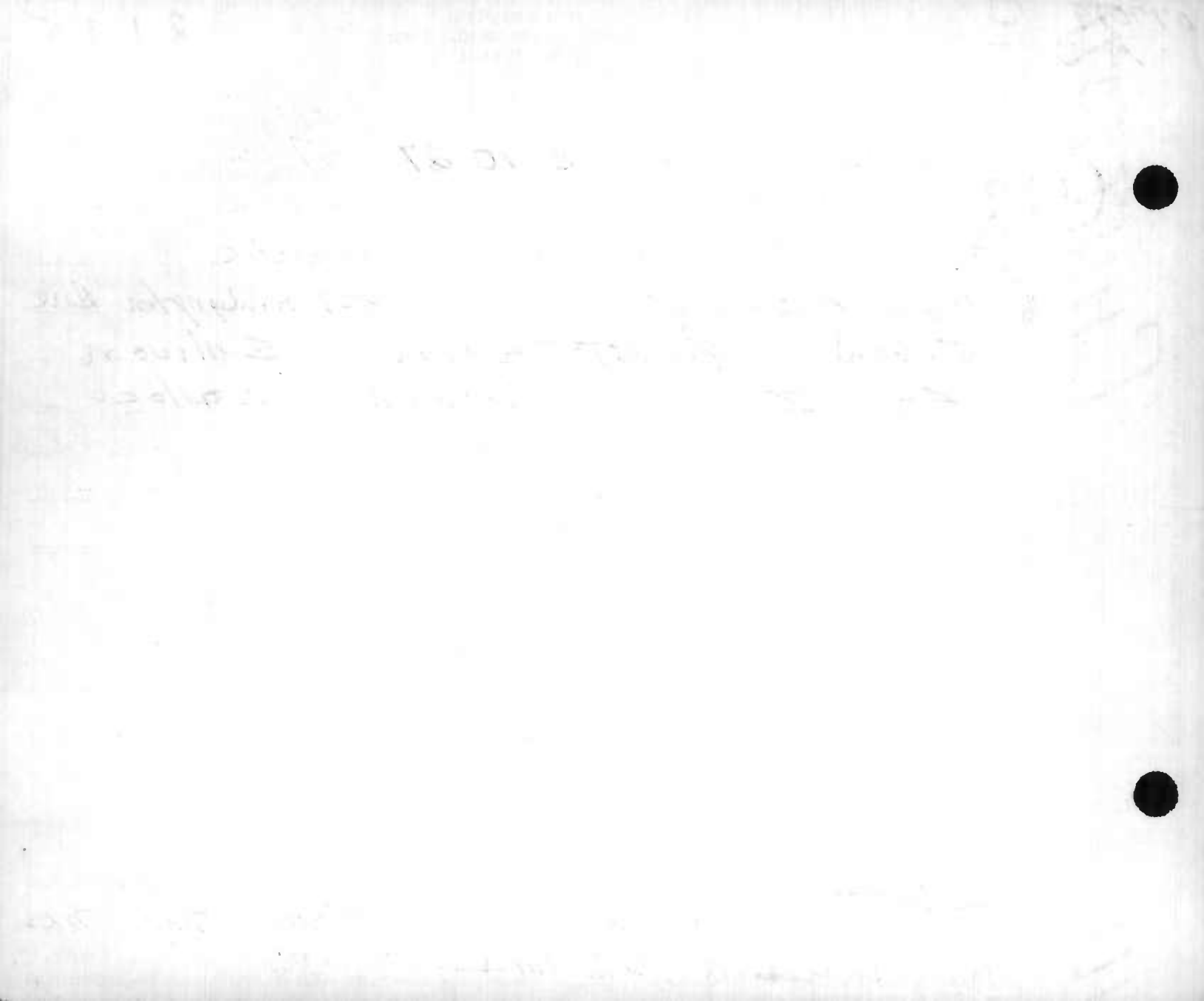
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified by the funeral director.

BP



086019

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8508136

1- FOR STATE REGISTRAR HELEN F. SULLIVAN

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) HELEN F. SULLIVAN			2a. DATE OF DEATH MONTH DAY YEAR MARCH 24, 1985			2b. HOUR 10:28 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 22, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 205 Beaumont Avenue 21228		
4. FATHER'S NAME FIRST MIDDLE LAST Frank Hess				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Kahler							
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 162-14-0180		17. INFORMANT Nancy Bateman				ADDRESS 2117 Edmondson Avenue Baltimore, Md. 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHIO PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PERITONITIS</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (he/she/it) attended the deceased from <u>FEB 16</u> , 19 <u>85</u> , to <u>MAR 24</u> , 19 <u>85</u> , that (he/she/it) last saw the deceased alive on <u>MAR 24</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Bert F. Morton</u>						DEGREE M.D.			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BERT F. MORTON</u>						22e. ADDRESS St. Agnes Hospital, Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3/25/85		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Md.			
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke 1630 Edmondson Avenue, Catonsville, Md. 21228						25a. DATE REC'D. BY REGISTRAR MAR 26 1985			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 2) should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HERMAN SULLIVAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 8, 1985</b>		2b. HOUR <b>7:43 AM</b>	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 2 16</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL 21205</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>--</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3637 Chestnut Ave. 21211</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Minor Sullivan</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Roseabelle Baker</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>225-16-0214</b>		17 INFORMANT ADDRESS <b>Patricia Sullivan 3637 Chestnut Ave. 21211</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>HEMORRHAGE 2° TO DIC 2° to CHF</b> (c) <b>CARDIOMYOPATHY</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>HEPATIC/RENAL INSUFFICIENCY</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1 MARCH 19 85</b> to <b>8 MARCH 19 85</b> , that (I) (we) last saw the deceased alive on <b>8 MARCH 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.						
22b. SIGNATURE <b>M. Earl Heard III</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8 MARCH 1985</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. EARL HEARD III</b>			22e. ADDRESS <b>600 N. WOLFE ST BALTO., MD. 21205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/12/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>
24 FUNERAL DIRECTOR NAME ADDRESS <b>A. Alan Seitz, Jr. 3615-19 Chestnut Ave. 212</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIOLA M SULLIVAN			2a. DATE OF DEATH MONTH DAY YEAR 3 - 23 - 85		2b. HOUR 4:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 - 10 - 99	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (COUNTRY) Baltimore Maryland	9. CITIZEN OF WHAT COUNTRY? USA	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
12. CITY OR TOWN OF DEATH BALTIMORE	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MASON F WOOD CHRONIC HOSPITAL		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE	15. KIND OF BUSINESS OR INDUSTRY —	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MD	16b. COUNTY BALTO	16c. CITY OR TOWN BALT	17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	18. STREET ADDRESS / ZIP CODE 8077 WALLACE RD 21222	
19. FATHER'S NAME FIRST MIDDLE LAST <del>Frederick C. Stock</del>		20. MOTHER'S MAIDEN NAME FIRST MIDDLE <del>Ellen</del> Chaffner			
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		22. SOCIAL SECURITY NO. 218-05-4960	23. INFORMANT Genevieve E. Brashears Caretaker 8077 Wallace Road - Balto., Md.		
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: SP Myocardial infarct x 4, DIABETES, RENAL INSUFFICIENCY					
25. DATE OF OPERATION —		26. CONDITION FOR WHICH OPERATION WAS PERFORMED —		27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	34. LOCATION STREET CITY OR TOWN COUNTY STATE		
35. I certify that (I) this hospital attended the deceased from 2-22, 19 85, to 3-23, 19 85, that (I) we lost saw the deceased alive on 3-23, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
36. SIGNATURE A J Lucco		37. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		38. DATE SIGNED 3-23-85	
39. PHYSICIAN'S NAME (TYPE OR PRINT) A J Lucco		40. ADDRESS 5200 EASTERN AVE. BALTO. MD 21224			
41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	42. DATE 3/26/85	43. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		44. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
45. FUNERAL DIRECTOR John A. Moran, Inc. Funeral Home 3000 E. Baltimore St., Balto., Md. 21224		46. DATE REC'D. BY REGISTRAR MAR 26 1985		47. REGISTRAR'S SIGNATURE —	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

Female  
Posterior

Frederick C. 2704

Chandler

Genevieve E. Brannons

21555  
21555

3000 E. Baltimore St., Baltimore, Md. 21224  
John W. Brown, Inc. Funeral Home  
Burial 3/25/65 Oak Lawn Cemetery  
Baltimore, Maryland



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 3 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED (TYPE OR PRINT) <b>SUR FRIEDA S SURASKY</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3 6 85</b>		2b. HOUR <b>12<sup>45</sup> M</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 19, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>LITHUANIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HELMAN MAYER HARRISON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PEARL UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-64-5545</b>		17. INFORMANT <b>WILLIAM SURASKY</b> <b>3111 TANEY RD. BALTO., MD 21215</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Carcinomatosis**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Cancer, bowel**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  
**Artery**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT (IF UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
**P.M. 19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐**STANLEY R. STEINBACH, M.D.****11 SLADE AVE. BALTO., MD 21208**23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
**BURIAL**23b. DATE  
**MAR. 7, 1985**23c. NAME OF CEMETERY OR CREMATORY  
**BETH ISRAEL**23d. LOCATION  
**BALTIMORE** COUNTY **MARYLAND**24. FUNERAL DIRECTOR  
NAME **SOL LEVINSON & BROS., INC.****6010 REISTERSTOWN RD. BALTO., MD 21215**25a. DATE REC'D BY REGISTRAR  
**MAR 14 1985**

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

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POST OFFICE

U.S. DEPARTMENT OF AGRICULTURE



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>SUWARDI, SUWARDI</b>			2a DATE OF DEATH MONTH DAY YEAR <b>MARCH 27, 1985</b>		2b HOUR <b>7:16<sup>AM</sup></b>	
3 SEX <b>M</b>		4 RACE <b>ORIENTAL</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>5/22/38</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>INDONESIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>INDONESIA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.						
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNK</b>		
12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>UNK</b>		13b. COUNTY <b>UNK</b>		13c. CITY OR TOWN <b>UNK</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>TEN KAM KIAM</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LAU KIAM TRIAO</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNK</b>		16b SOCIAL SECURITY NO. <b>NONE</b>		17 INFORMANT ADDRESS <b>DJUSANNE SUWARDI</b> <b>UNK</b>		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hepatic failure, Hepatorenal Syndrome</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Hepatosoma</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>4 months</b>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <b>March 25</b> 19 <b>85</b> , to <b>March 27</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>March 27</b> 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <b>Raymond W. Wilson</b>		DEGREE <b>MD</b>		22c DATE SIGNED <b>27 March 1985</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Raymond W. Wilson, MD</b>		22e ADDRESS <b>The Johns Hopkins Hospital</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>3/27/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SECURITY PROCESS</b>		
23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>						
24 FUNERAL DIRECTOR NAME <b>J.G. CONNELLY</b>		ADDRESS <b>300 MACE</b>		25a DATE REC'D. BY REGISTRAR <b>MAR 28 1985</b>		
25b REGISTRAR'S SIGNATURE <b>Wardson Handell</b>						

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that death certificate be executed within 24 hours of a death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be detached for use as the burial-transit permit. They please remove correct page 4 and page 5 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8508141

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hilda Swain		2a. DATE OF DEATH MONTH DAY YEAR 03 17 85		2b. HOUR 8:40 am	
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 11 14 1918		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Franklin Null		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Christina Bishop		13e. STREET ADDRESS / ZIP CODE 5624 A Woodmont Ave. 21239	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-38-5268		17. INFORMANT ADDRESS William E. Swain - 535 Hudson St., Apt. 3G New York, N.Y. 10014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sudden Death DUE TO, OR AS A CONSEQUENCE OF (c) Stroke PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Sick Sinus Syndrome					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/10 1985 to 3/17 1985, that (I) (we) last saw the deceased alive on 3/10 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rudolph Morick		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/17/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rudolph Morick		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-20-85		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		23e. NAME OF FUNERAL DIRECTOR 1050 York Rd. Ruck Towson Funeral Home, Inc. Towson, Md. 21204			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page number be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 5 0 8 1 4 2 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Nathaniel R. Sye</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>March 3-8-85</u> 2b. HOUR <u>4 05 P.M.</u>			
3. SEX <u>Male</u>		4. RACE <u>Negro</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Oct. 11 1929</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>55</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Francis Scott Key Medical</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Steel Worker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	
13a. STATE <u>Md.</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. STREET ADDRESS <u>1507 N. Potomac St.</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Robert Blackmon</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mildred Handy</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>220242959</u>		17. INFORMANT ADDRESS <u>Sarah Sye/ 764 Linnard St/Balto.Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>IntraCerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>3/8 1985</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/8 1985</u> to <u>3/8 1985</u> , that (I) (we) lost <u>saw the deceased alive on 3/8 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED <u>3-8-85</u>	
22b. SIGNATURE <u>David Grace</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>David Grace</u>		22e. ADDRESS <u>4940 Eastern Ave</u>					
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE <u>3-13-85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Arbutus (Balto.) Md.</u>	
24a. FUNERAL DIRECTOR <u>Marshall W. Jones, JR.</u>				24b. ADDRESS <u>4101 Edmondson Ave</u>		24c. DATE REC'D. BY REGISTRAR <u>MAR 13 1985</u>	
				24d. REGISTRAR'S SIGNATURE <u>Davidson Nordell</u>			



7

CHIEF

100



BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 4 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ARNOLD E. TABB</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 / 9 / 85</b>			2b. HOUR <b>6:52 P.M.</b>					
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 24 1940</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Assembly Line Worker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>General Motors</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4013 Penhurst Avenue Baltimore, Maryland 21215</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Edward Tabb</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Myrl C. Ball</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>219-26-2437</b>			17. INFORMANT <b>Myrl C. Ball</b> ADDRESS <b>4013 Penhurst Avenue Baltimore, Maryland 21215</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>9 a.m. 3/9 / 19 85</b> , to <b>6:52 pm 3/9, 19 85</b> , that (1) (we) lost saw the deceased alive on <b>3/9 / 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>F.M. Gloth</b>						DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3/9/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F.M. GLOTH</b>						22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/13/1985</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Veterans</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24. FUNERAL HOME OR OTHER PERSON TO WHOM BODY WAS DELIVERED NAME ADDRESS <b>K. Mather &amp; Sons 2501 Gwynns Falls Parkway Funeral Home, Inc. Baltimore, Maryland 21216</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1985</b>			25b. REGISTRAR'S SIGNATURE <b>F. Davidson-Randall</b>		

MEDICAL CERTIFICATION

100-100000



RECEIVED

BALTIMORE CITY

UNION MEMORIAL HOSPITAL

BALTIMORE

General

Association of the Baltimore

Baltimore, Maryland 21212

Director

Medical

Bill

C.

Wm

Ed

Ed

Ed

2015 Lombard Avenue

21212-21212 Wm C. Bill Baltimore, Maryland 21212

UNION MEMORIAL HOSPITAL

P.H. DEATH

Baltimore, Maryland

21212-21212 Wm C. Bill Baltimore, Maryland 21212

21212-21212 Wm C. Bill Baltimore, Maryland 21212

21212-21212 Wm C. Bill Baltimore, Maryland 21212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

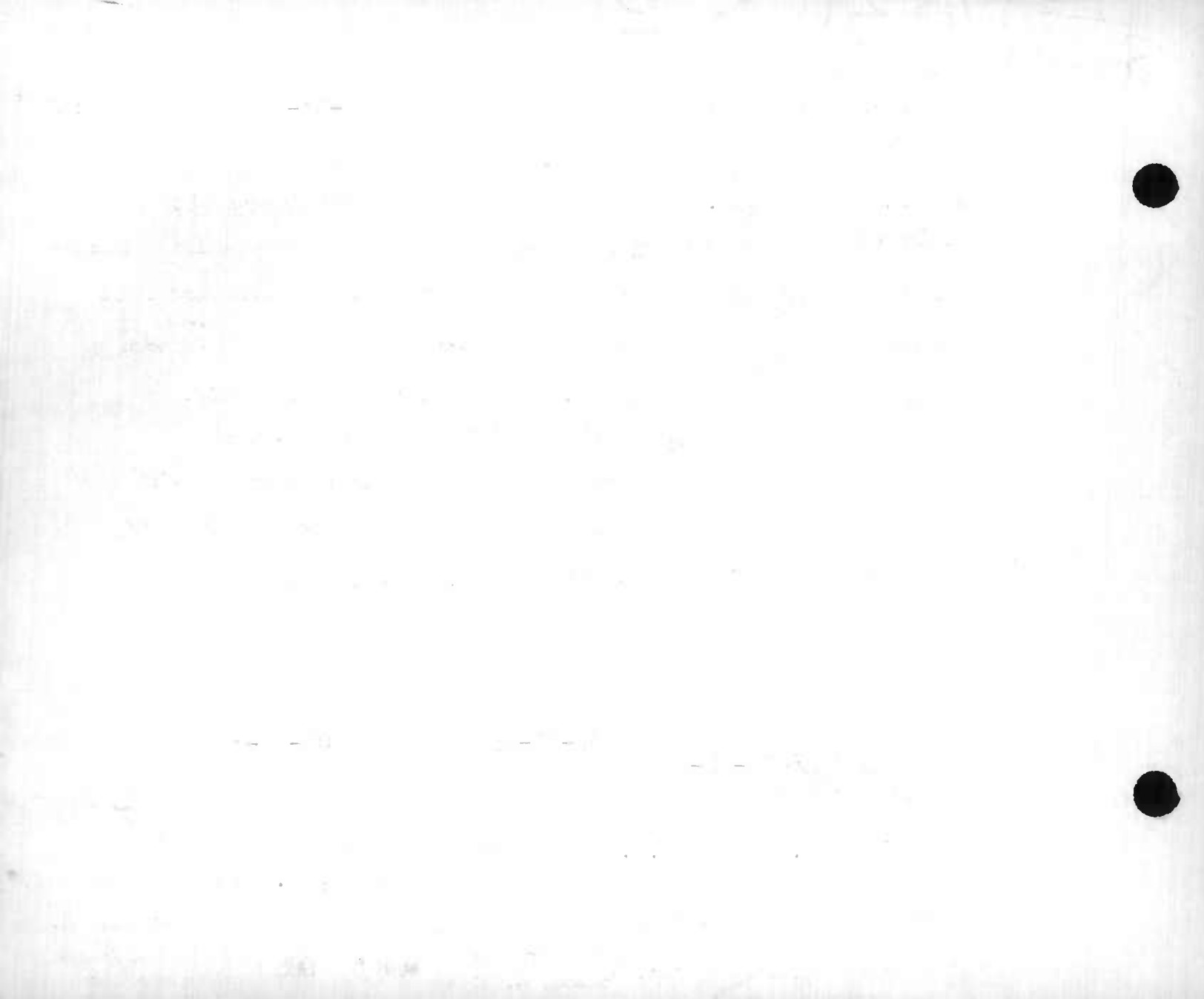
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HERMAN n Dave Tabor</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03-03-85</b>		2b. HOUR <b>3:50 M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 4, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Belair Convalesarium</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager - Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Theater</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lutherville</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Unknown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-03-2388</b>		17. INFORMANT ADDRESS <b>Dolores Yewell Same as #13/.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BEVERE ANEMIA DUE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>TO BONE MARROW FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC CONGESTIVE FAILURE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>PRE LEUKEMIA SYNDROME</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>03-01-85</b> 19 to <b>03-03-85</b> 19, that (I) (we) last saw the deceased alive on <b>03-02-85</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.					
22b. SIGNATURE <b>Rivera</b>		DEGREE		22c. DATE SIGNED <b>3/7/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Luis E. Rivera, M.D.</b>		22e. ADDRESS <b>54 Scott Adam Road Cockeysville, Md. 21030</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>March 6, 1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville Baltimore, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>		ADDRESS <b>1050 York Road Towson, Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 6 1985</b>	
		25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>			

BP



087101

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST <b>CELIA</b>		MIDDLE		LAST <b>TAKSAR</b>		2a. DATE OF DEATH			MONTH <b>3</b>	DAY <b>17</b>	YEAR <b>85</b>	2b. HOUR <b>7:20</b> AM
3 SEX <b>F</b> FEMALE		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>OCTOBER 10, 1899</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> - 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.								
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVINDALE HEBREW HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>						
13a. STATE <b>MARYLAND</b>				13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3624 FORDS LA., APT. B #21215</b>				
14 FATHER'S NAME FIRST <b>JACOB</b>				MIDDLE		LAST <b>SCHWARTZ</b>		15 MOTHER'S MAIDEN NAME FIRST <b>SOPHIE</b>		MIDDLE		LAST <b>UNKNOWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-66-0378</b>		17 INFORMANT <b>MRS. ROBERT KATZOFF</b> <b>2307 HANWAY RD. BALTO., MD 21209</b>										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) _____														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>cerebro-vascular accident, ASCVD</b>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>3/17/85</b> to <b>3/17/85</b> , that (we) lost saw the deceased alive on <b>3/17/85</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/17/85</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KHIN M. TUN</b>				22e. ADDRESS <b>Levindale Geriatric Hospital</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MAR. 18, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMUNO</b>		23d. LOCATION <b>BALTIMORE</b>		COUNTY <b>MARYLAND</b>						
24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>				25a. DATE RECEIVED BY REGISTRAR <b>MAR 22 1985</b>										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled with information about the death. The funeral director should be notified of the death as soon as possible.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information about the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death as soon as possible.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Boris</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03-15-85</b>			3b. HOUR <b>7:52 AM</b>			
3 SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 25, 1896</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVINDALE</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SUPPLIER</b>		12b BUSINESS OR INDUSTRY <b>FISHING BAIT</b>	
13a STATE <b>MARYLAND</b>			13b COUNTY <b>BALTIMORE</b>		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>MORRIS</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MIRIAM RAVINSKY</b>			13e STREET ADDRESS / ZIP CODE <b>5534 NOME AVE. #21215</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b SOCIAL SECURITY NO. <b>220-05-1400</b>		17 INFORMANT <b>JOSEPH TAMPTCO</b> APT. 11 <b>8764 CLOUDLEAP CT. COLUMBIA, MD 21045</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>METASTATIC CA OF THE PANCREAS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1984</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ISCHEMIC HEART DISEASE</b>									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>2-28</b> , 19 <b>85</b> , to <b>3-15</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3-15</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>B. ZAW-WIN</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>03-15-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. ZAW-WIN</b>						22e ADDRESS <b>LEVINDALE GERIATRIC BALTO 21215</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b DATE <b>MAR. 17, 1985</b>		23c NAME OF CEMETERY OR CREMATORY <b>OHEL YAKOV</b>		23d LOCATION BALTIMORE COUNTY MARYLAND		
24 FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>						25a DATE REC'D. BY REGISTRAR <b>MAR 19 1985</b>		25b REGISTRAR'S SIGNATURE <b>Sol Levinson</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR						
FIRST MARY MIDDLE A. LAST TANSEY			3			16			85			3:16 AM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS						
FEMALE			WHITE			MONTH 5 DAY 1 YEAR 96			88			YRS.			MONTHS DAYS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH												
Maryland			U.S.A.						Baltimore City			MD.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Baltimore			Bon Secours Hospital			Homemaker			---												
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
Maryland						Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			301 N. Calverton Road			21223						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																		
FIRST MIDDLE LAST Patrick Tansey			FIRST MIDDLE LAST Ellen Porter																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS												
NO			213-48-6603			Sr. Margaret			601 Maiden Choice La.			21228									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) Metastatic CA of Ovary																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																					
(b) C. H. F																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c) Renal failure																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																					
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
Approx. 6 weeks ago												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
						HOUR A.M. MONTH DAY YEAR						N.A.									
21d. INJURY OCCURRED						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21f. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK												STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 3-5-85 to 3-16-85, that (I) (we) last saw the deceased alive on 3/15/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE														22c. DATE SIGNED							
Jogendra Singh MD														3/15/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)														22e. ADDRESS							
JOGENDEA SINGH														1190 W. NORTHERN Pkwy							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
Burial				3/20/85				New Cathedral Cem.				Baltimore									
												CITY OR TOWN COUNTY STATE									
												Maryland									
24. FUNERAL DIRECTOR														25a. DATE RECEIVED BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS 21229														MAR 20 1985				John Anderson Handell			
Hubbard Funeral Home, Inc. 4107 Wilkens Ave.																					

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR 3/15/85 rja  
1- STATE REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Robert W. Tansill, Sr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>March 11, 1985</i>			2b. HOUR M <i>M</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 15, 1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>64</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Balto. Gen. Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Machine Shop</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>factory</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>				13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William B. Tansill</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katherine L. Mitchell</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (YES, GIVE WAR OR DATES) <i>W.W. 2 214-18-6641</i>		17. INFORMANT ADDRESS <i>Mrs. Catherine Tansill, Same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i> <i>3 yr 1</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-25</i> , 19 <i>79</i> , to <i>3-11</i> , 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>3-11</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W. W. Tansill</i>				DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3-12-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>March 14, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ledar Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>	
24. FUNERAL DIRECTOR <i>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 12 1985</i>		25b. REGISTRAR'S SIGNATURE <i>W. W. Tansill</i>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY STROBEL TARBERT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 19, 1985</b>		2b. HOUR <b>2:14 AM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 20 95</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>99</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RESWICK</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Reg. Nurse</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>223 E. Belvedere Ave. 21212</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Upton Tarbert</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Strobel</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>007-20-7445</b>		17. INFORMANT ADDRESS <b>Mr. William Tarbert 17220 York Rd. Parkton, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HASCD</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WK</b> <b>2 MOS</b> <b>10 YRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from <b>OCT 30 1986</b> to <b>3-19 1985</b> , that (we) lost saw the deceased alive on <b>3-19 1985</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John F. Hartman</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3-19-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN F. HARTMAN</b>		22e. ADDRESS <b>700 N. 40th St. Balto. Md. 21211</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>	23b. DATE <b>3/19/85</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>			ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 21 1985</b>
					25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rendell</b>

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHMH - 16 50M 4/83  
(VRA 15, 4)

Handwritten notes and signatures at the top of the page, including a signature that appears to be "John F. Hartman".

Handwritten notes in the middle section, including the phrase "GASTROINTESTINAL" and other illegible text.

Handwritten notes at the bottom of the page, including the name "John F. Hartman" and other illegible text.



085012

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Percell Eric Tates</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 16, 1985</b>		2b. HOUR <b>12:30A</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 3 1953</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>31</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>21217</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1306 Pennsylvania Ave. Apt. B12 Balto. Md.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Waters C. Tates</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine L. Williams</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>214-56-7961</b>		17. INFORMANT ADDRESS <b>Valerie Tates B-12 Baltimore, Maryland 21217</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adult Respiratory Distress Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Staphylococcus Aureus Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Intravenous Drug Abuse</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Eight Days</b> <b>Two Weeks</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Staphylococcal Endocarditis, Nephrotic Syndrome, Diabetes Mellitus</b>					
19a. DATE OF OPERATION <b>March 9, 1985</b> <b>Open Lung Biopsy</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Adult Respiratory Distress Syndrome</b>		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 4, 1985</b> , to <b>March 16, 1985</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 16, 1985</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Gail A. Glotfelty, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3/16/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gail A. Glotfelty, M.D.</b>		22e. ADDRESS <b>c/o Maryland General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/21/1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL HOME NAME <b>Nutter &amp; Sons</b>		2501 Gwynns Falls Parkway ADDRESS <b>Funeral Home, Inc. Baltimore, Maryland 21216</b>		MAR 20 1985	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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081078

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 08151

FOR 1. STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Frederick Taylor</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>3-14-85</i> 2b. HOUR <i>1:30 pm</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>12 11 02</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Alabama</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>82 82</i> YRS. 8. UNDER 1 YEAR 9. UNDER 1 YEAR MONTHS DAYS HOURS MINS.	
12. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hospital INC.</i>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Marine</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Military</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>120-24-9529</i>	
17. INFORMANT ADDRESS <i>3803 Cedarhurst Rd. Baltimore, Md.</i>		17. INFORMANT NAME <i>Mr. Earl Tuma</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sepsis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Renal failure, lymphoma, ileus, multifocal atrial tachycardia</i>			
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>	
20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>— P.M. 19</i>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i>	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>—</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 24, 1985</i> to <i>March 14, 1985</i> , that (I) (we) lost saw the deceased alive on <i>March 14, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Helen Walker</i>		22c. DATE SIGNED <i>3/14/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Helen Walker</i>		22e. ADDRESS <i>Mercy Hospital</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		23b. DATE <i>3/18/85</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>—</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i>		25. DATE REC'D. BY REGISTRAR <i>MAR 21 1985</i>	
ADDRESS <i>Balto., Md.</i>		25. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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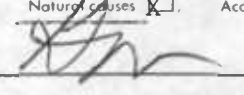

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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 DHMH - 17  
 (VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08152	
1. DECEASED NAME (TYPE OR PRINT) <b>June E. Taylor</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3/ 9/ 1985		2b. HOUR <b>M</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 7, 1925</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>60</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 3/11/ 1985		2d. HOUR <b>10:55</b> <b>P M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3808 Echodale Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teller</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3808 Echodale Ave. 21206</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clarence Taylor, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Messick</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-20-6560</b>		17. INFORMANT ADDRESS <b>Clarence Taylor, Jr. 26 Tenbury Road</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 					TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER			DATE SIGNED <b>3/12/85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>					ADDRESS <b>111 PennSt.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>March 14, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville Maryland</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1985</b>		25b. REGISTRAR'S SIGNATURE 				



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

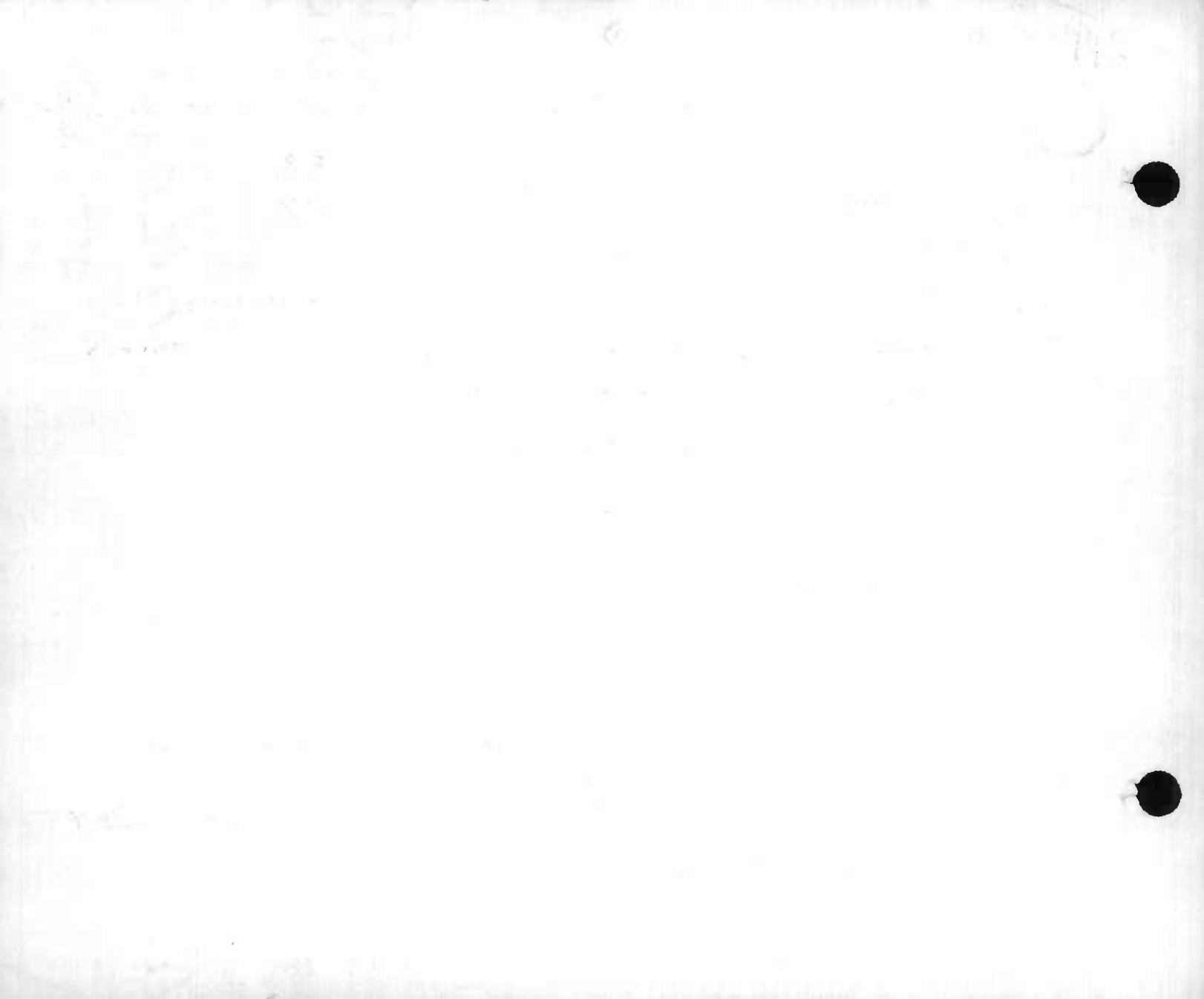
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Leon</u> MIDDLE <u>A</u> LAST <u>Taylor</u> <u>Leon A Taylor</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>3</u> <u>24</u> <u>85</u>		2b. HOUR <u>2:15 PM</u>
3. SEX <u>M</u>	4. RACE <u>B</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>10</u> <u>6</u> <u>18</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>66</u> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Cty</u> MD.
10. CITY OR TOWN OF DEATH <u>Balt</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sinai Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <u>MD</u>	13b. COUNTY	13c. CITY OR TOWN <u>Balt</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <u>Kurtis</u> MIDDLE LAST <u>Taylor</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Clara</u> MIDDLE LAST <u>Harris</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>Marie Taylor</u> ADDRESS <u>5308 Denmore Ave</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Serious</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>metastatic Cs</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. SIGNATURE <u>Steven Lerman</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Steven Lerman</u>		22c. DATE SIGNED <u>3/24/85</u>		
22d. ADDRESS <u>Sinai Hospital</u>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		
23b. DATE <u>3/29/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Basil Church Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Cockeysville MD</u>
24. FUNERAL DIRECTOR NAME <u>Wm C March F/H</u> ADDRESS <u>1101 E North Ave.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 26 1985</u>		
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>				

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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080064

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 5 0 8 1 5 4	
1 - FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) <b>THOMAS H. TAYLOR</b>			2a DATE OF DEATH MONTH DAY YEAR <b>March 18, 1985</b>		2b HOUR <b>7:20A<sub>M</sub></b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>01 01 09</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bethlehem Steel</b>		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN <b>Maryland Baltimore Dundalk</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>1716 Rita Rd. 21222</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles Taylor</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Wood</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b SOCIAL SECURITY NO. <b>213-07-0696</b>		17 INFORMANT ADDRESS <b>Beatrice Taylor 1716 Rita Rd. 21222</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>March 16, 1985</b> to <b>March 18, 1985</b> , that (I) (we) last saw the deceased alive on <b>March 18, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Paul E. Gormley</i>		DEGREE <b>MD</b>		22c DATE SIGNED <b>3/19/85</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL E. GORMLEY, M.D.</b>		22e ADDRESS <b>CHURCH HOSPITAL 100 N. Broadway, Balto., MD 21231</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>3/21/85</b>		23c NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
23d LOCATION CITY OR TOWN <b>Baltimore, Md.</b>		STATE			
24 FUNERAL DIRECTOR <b>Connelly Funeral Home of Dundalk</b>				25a DATE REC'D. BY REGISTRAR <b>MAR 19 1985</b>	
				25b REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

RECEIVED

DEPT

NOTED





085124

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8155

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM BARTGIS TAYLOR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 18 85</b>		2b. HOUR <b>8:20 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 26 1901</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>83</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>REP/CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GOVT.</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>CATONSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1208 EDMONDSON AVENUE 21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank D. Taylor</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jessie Thompson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW11</b>		16b. SOCIAL SECURITY NO. <b>219-4246007</b>		17. INFORMANT ADDRESS <b>Mary B. Taylor Same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pulmonary edema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>acute myocardial infarction</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>					
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3/18 85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>SAINT AGNES HOSPITAL BALTIMORE MD</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/18 85</b> to <b>3/18 85</b> , that (I) (we) last saw the deceased alive on <b>3/18 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John P. Lavery</b>		DEGREE <b>MD.</b>		22c. DATE SIGNED <b>3/19/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN PLAVERY</b>		22e. ADDRESS <b>SAINT AGNES HOSPITAL BALTIMORE MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3-19-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>		23e. DATE REC'D. BY REGISTRAR <b>MAR 21 1985</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>MacNabb Funeral Home Catonsville Md</b>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

2218

082134



086044

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

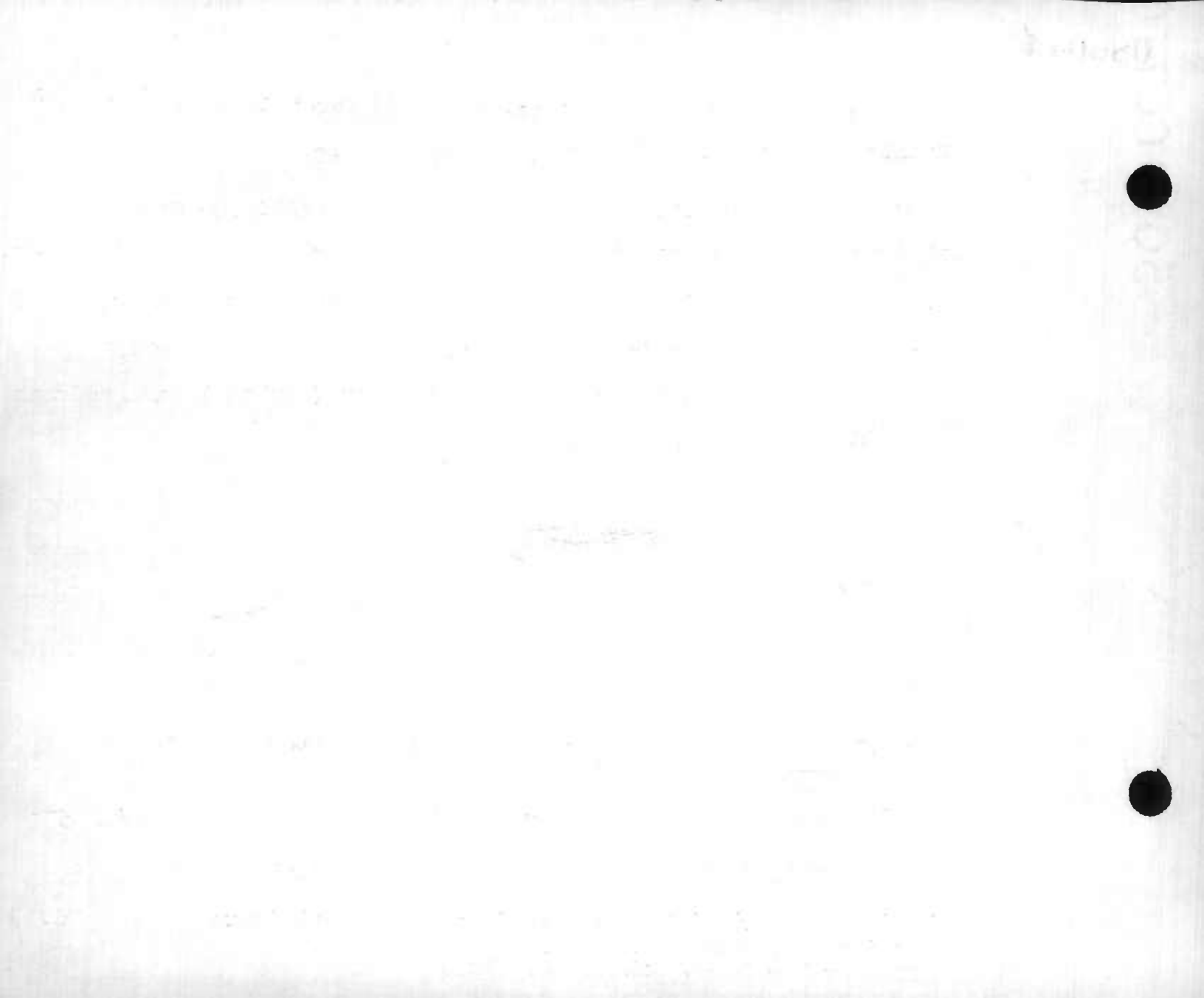
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen M. Tessler			2a. DATE OF DEATH MONTH DAY YEAR March 25 1985			2b. HOUR A M 1:30 A				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 9 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4334 Parkside Drive 21206				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Refinery Co.		
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4334 Parkside Dr. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST Leon Emilinski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rybick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-09-0152		17. INFORMANT ADDRESS Frank Tessler (husband) same address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>THYROID CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>HYPERTENSION</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>Oct 10</u> , 19 <u>84</u> , to <u>MAR 18</u> , 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>18 MAR</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>DG Carlson</u>			DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>25 MAR 85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DG CARLSON MD,</u>			22e. ADDRESS <u>Brehms Medical Center</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>3/28/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Schimunek Funeral Home Inc.</u> <u>3331 Brehms Lane, Balto. Md. 21213</u>					25a. DATE REC'D. BY REGISTRAR <u>MAR 26 1985</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at page 3.



079099

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 5 7

FOR  
1- STATE  
REGISTRAR

REG. NO.

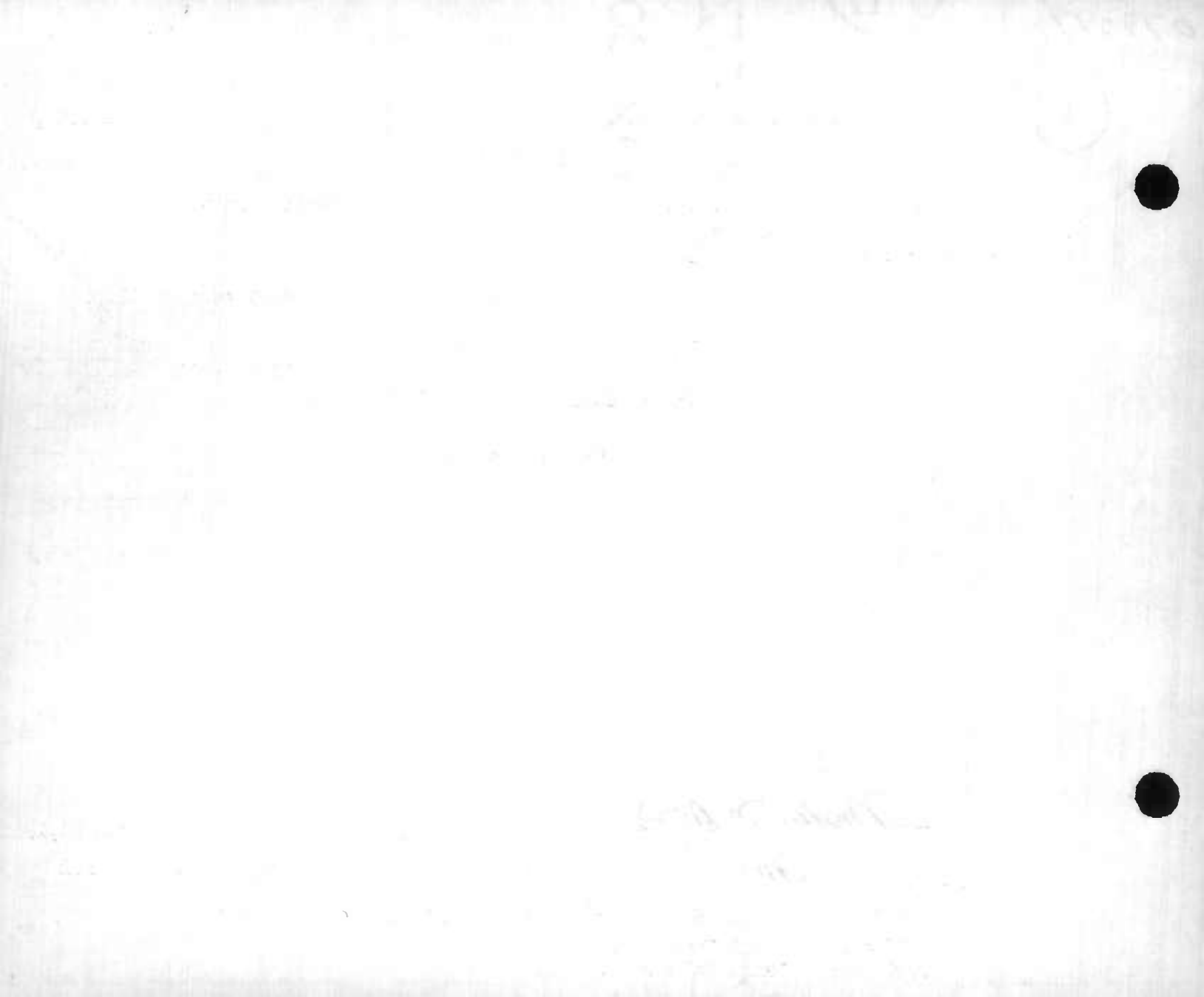
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Allen W. Thoman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 14, 1985</b>		2b. HOUR <b>12:50 AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 15 1915</b>		6. AGE YRS. MONTHS DAYS <b>69</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Perry Point</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plumber</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>
13a. STATE <b>Md.</b>		13b. COUNTY <b>-</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. STREET ADDRESS / ZIP CODE <b>4209 Seidel Avenue 21206</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Adam Thoman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Kunkle</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 213 10 5892</b>		17. INFORMANT <b>13016 Bottom Rd. Hydes, Md. 21082</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 5, 1985</b> to <b>March 14, 1985</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Christopher M. Atay</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>March 14, 1985</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. N. ATAY</b>		22e. ADDRESS <b>VA Medical Center, Parry Point, MD 21902</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/18/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Owings Mills, Md.</b>	23e. DATE REC'D. BY REGISTRAR <b>MAR 15 1985</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Schmunek Funeral Home Inc. 3331 Brehms Lane, Balto. Md. 21213</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 15 1985</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



077060

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES W. THOMAS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 28, 1985</b>			2b. HOUR A <b>1:07 M</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 14 1962</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>22 YRS</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>22 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Herman Thomas</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Patsy Shirleen Carroll</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>294-62-2266</b>		17. INFORMANT <b>Patsy Fettes</b>		ADDRESS <b>P.O. Box 375 Davy, W.Va. 24828</b>	

18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Pulmonary Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 Minutes</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Brain Death</b>		<b>56 hours</b>
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/25</b> 19 <b>85</b> , to <b>2/28</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>2/28</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Raymond Henry Plach</b>				DEGREE		22c. DATE SIGNED <b>2/28/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Raymond Henry Plach MD</b>				22e. ADDRESS <b>600 N. WOLFE ST. BALTO. MD.</b> <b>Johns Hopkins Hospital 21205</b>			

23a. BURIAL, CREMATION, REMOVAL RECEIVED <b>Burial</b>		23b. DATE <b>3/3/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Justice Cemetery</b>		23d. LOCATION TOWN <b>Davy McDowell W. VA.</b>	
24. FUNERAL DIRECTOR NAME <b>7922 Wise Ave. Dundalk, MD 21222</b> <b>Duda-Ruck Funeral Home of Dundalk, Inc.</b>				DATE REC'D. BY REGISTRAR <b>MAR 14 1985</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the hospital or attending physician. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

2025 COTTON FIBER

DAVID J. AND  
DAVID J. AND





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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES B. THOMAS			2a. DATE OF DEATH MONTH DAY YEAR 3 23 85			2b. HOUR 6 AM					
3. SEX M		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 07 31		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CHICAGO, ILL.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.					
10. CITY OR TOWN OF DEATH BALTO CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE. 2213 W. Lexington St. 21223		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Thomas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Juanita Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. Korean 318-22-4698		17. INFORMANT ADDRESS Sarah Thomas 2213 W. Lexington St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordae Aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) Multiple organ failure DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis - Pseudomonas Aeruginosa PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes - Pneumonia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION 3-1-85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ULCEROSIS STUMP (2)			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/22/85, 19_____, to 3/23/85, 19_____, that (I) (we) last saw the deceased alive on 3/22/85, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE PEZAYO E. CORREA						DEGREE		22c. DATE SIGNED 3/23/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PEZAYO E. CORREA						22e. ADDRESS LUTHERAN HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 03-28-85		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Cem. Baltimore, MD.			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Brown/Thompson F.H. 13 W. Baltimore St.											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			3. SEX			4. RACE		
FIRST MIDDLE LAST JOHN H THOMAS			MALE			Black		
5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BALTIMORE CITY OR COUNTY OF DEATH		
MONTH DAY YEAR 5 09 03			81			Baltimore City MD.		
8. BIRTHPLACE (STATE OR FOREIGN)			9. CITIZEN OF WHAT COUNTRY?			10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		
Ga.			USA			Lutheran Hosp.		
11. CITY OR TOWN OF DEATH			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			(TYPE OF WORK FOR MOST OF WORKING LIFE)					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
N.J.			Trenton			13d. INSIDE CITY LIMITS?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
FIRST MIDDLE LAST Unkn			FIRST MIDDLE LAST Unkn			(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		
16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
157-03-9515			Bessie Thomas			101 New York Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) _____								
DUE TO, OR AS A CONSEQUENCE OF								
(c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR P.M. 19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>3-20-85</u> , to <u>3-15-85</u> , that (I) (we) lost saw the deceased alive on <u>3-15-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<u>Marks</u>						3-15-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
A. Mathew			Lutheran Hospital 730 Ashburton St. Baltimore, MD.					
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			3/21/85			Greenwood Cem.		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME Wm C. March F/H			ADDRESS 1101 E. North Ave.			MAR 18 1985		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Willie Thomas								XX		3-13		19		85		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	7/16/1955		29 YRS.						3-14		19		85		11:46 a. M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Balto., Md.		U.S.A.				Baltimore City, MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		4601 E. Monument St.-Room #38		Laborer		So. Chemic											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3808 Norfolk Ave. 21216									
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
Enoch Thomas						Beatrice Jackson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
no												Mrs. Ruby Shuler 3808 Norfolk					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Narcotism</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) <u></u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) <u></u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
						P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION					
												STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED					
<i>Dennis F. Smyth</i>						M.D. Assistant						3-14-85					
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS											
Dennis F. Smyth, M.D.						111 Penn St., Balto., Md.						21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY STATE			
Burial				3/20/85		King Mem. Park				Randallstown				Md.			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
NAME ADDRESS						18 1085						<i>Davidson</i>					
James A. Morton & Sons 1701 Laurens																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>George Washington Thompson</b>			7a. DATE OF DEATH MONTH DAY YEAR <b>3-19-85</b>			7b. HOUR <b>3:50 P</b>					
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02-22-99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>HARFORD</b>			13c. CITY OR TOWN <b>EDGEWOOD</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT THOMPSON</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMA THOMPSON</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>1343 HARFORD SQUARE DRIVE 21040</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>1761834294</b>			17. INFORMANT ADDRESS <b>MR ARNOLD THOMPSON 1343 HARFORD SQUARE DRIVE EDGEWOOD MD 21040</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypovolemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GI bleeding</b>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>COPD</b>	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			70a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3/7 19 85</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>LUTHERAN HOSPITAL</b>			21g. DATE SIGNED <b>3/19/85</b>			21h. SIGNATURE <b>BICH T DUONG</b>		
21i. I certify that (I) (this hospital) attended the deceased from <b>3/7</b> , 19 <b>85</b> , to <b>3/19</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/19</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			21j. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BICH T DUONG</b>			21k. ADDRESS <b>LUTHERAN HOSPITAL</b>			21l. DATE REC'D. BY REGISTRAR <b>MAR 22 1985</b>		
23a. BURIAL, CREMATION, REMOVAL (CHECK) <b>CREMATION</b>			23b. DATE <b>3-25-85</b>			23c. NAME OF CEMETERY OR CREMATORY <b>LAUREL PARK</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>		
24. FUNERAL DIRECTOR NAME <b>LOUIS L. RUSS 2222 W. NORTH AVE</b>			24a. DATE REC'D. BY REGISTRAR <b>MAR 22 1985</b>			24b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			24c. REGISTRAR'S SIGNATURE		



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Elizab<sup>th</sup> S. Thompson</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>3/ 3/14/85</i>		2b. HOUR <i>1:45 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 2 88</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>96</i> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>MD</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Smith</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>---</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-22-0375</i>		17. INFORMANT ADDRESS <i>Gertrude Elliott 3116 Presstman St.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>3/16 85</i> P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>3/14 85</i> <i>3/14 85</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/16 85</i> to <i>3/14 85</i> , that (I) (we) last saw the deceased on <i>3/14 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) see the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>3/14/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ARBUSUSO, J.</i>		22e. ADDRESS <i>730 Ashburton St. Baltimore 21216</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/18/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Pk.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Co. MD</i>		23e. NAME OF CEMETERY OR CREMATORY			
24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H</i>		ADDRESS <i>1101 E. North Ave.</i>		25. DATE OF DEATH <i>3/16/85</i>	
26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		27. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN - The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR - After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR <i>Maryland</i>					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) <i>Laura Leona Thompson</i>					2a DATE OF DEATH MONTH <i>3</i> DAY <i>11</i> YEAR <i>85</i>			2b HOUR <i>3 A</i> M	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH <i>10</i> DAY <i>14</i> YEAR <i>05</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> IF UNDER 24 HRS HOURS <i></i> MIN. <i></i>	
7a BIRTHPLACE (STATE OR FOREIGN) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Balto City</i> MD.			
10 CITY OR TOWN OF DEATH <i>Baltimore</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Balt. Gen. Hosp</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Home Maker</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a STATE <i>MD</i>		13b COUNTY <i>Balt.</i>		13c CITY OR TOWN <i>Balt.</i>		13e STREET ADDRESS / ZIP CODE <i>3900 10th St. 21225</i>			
14 FATHER'S NAME FIRST <i>William</i> MIDDLE <i>R</i> LAST <i>Russell</i>					15 MOTHER'S MAIDEN NAME FIRST <i>Laura</i> MIDDLE <i>Mae</i> LAST <i>Shorter</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>21 6207388</i>		17 INDECANT <i>Glen Burnie, Md 21061</i> <i>Thomas Thompson 7679 Turnbrook Grive,</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic shock</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>leukemia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21i LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <i>February 25</i> , 19 <i>85</i> , to <i>March 11</i> , 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>March 11</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Paul Warshawsky M.D.</i> DEGREE <i>House</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>					22c DATE SIGNED <i>3/11/85</i>				
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Paul Warshawsky / Aaron Berkman MD</i>					22e ADDRESS <i>South Baltimore General Hospital 3473200</i>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>3/14/85</i>		23c NAME OF CEMETERY OR CREMATORY <i>Crestlawn Mem Park</i>		23d LOCATION CITY OR TOWN <i>Sykesville</i> COUNTY <i>Carroll</i> STATE <i>Md</i>			
24 FUNERAL DIRECTOR NAME <i>George J. Gonce</i> ADDRESS <i>4001 Ritchie Hwy Balto Md</i>					25a DATE REC'D BY REGISTRAR <i>MAR 14 1985</i>		25b REGISTRATION NO. <i>141414</i>		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

## MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP 1073  
DHMH - 17  
(VR A15 ME (5))



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROLAND - THOMPSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 6 85</b>		2b. HOUR <b>9 PM</b>						
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 4 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		8. IF UNDER 24 HRS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK (OR MOST OF WORKING LIFE)) <b>ELECTRO-PLATER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BENDIX</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>						13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE THOMPSON</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LENA HENRY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>YES WW II</b>		16b. SOCIAL SECURITY NO. <b>213-09-5798</b>		17. INFORMANT ADDRESS <b>4401 PARKMONT AVE. 21206</b>		17. INFORMANT ADDRESS <b>LORETTA PULLARA (DGHTER)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION, INFERO-POSTERIOR</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>POSTERIOR</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>RECENT OCCLUSION RIGHT CORONARY ARTERY</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE <i>Michael J. Pagan</i>						DEGREE <b>MS</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/7/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3/9/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CRESTLAWN CEMETERY</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>			
24. FUNERAL DIRECTOR NAME <b>SCHIMUNEK FUNERAL HOME, INC.</b>						25a. DATE RECEIVED BY REGISTRAR <b>MAR 8 1985</b>					
24. FUNERAL DIRECTOR ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

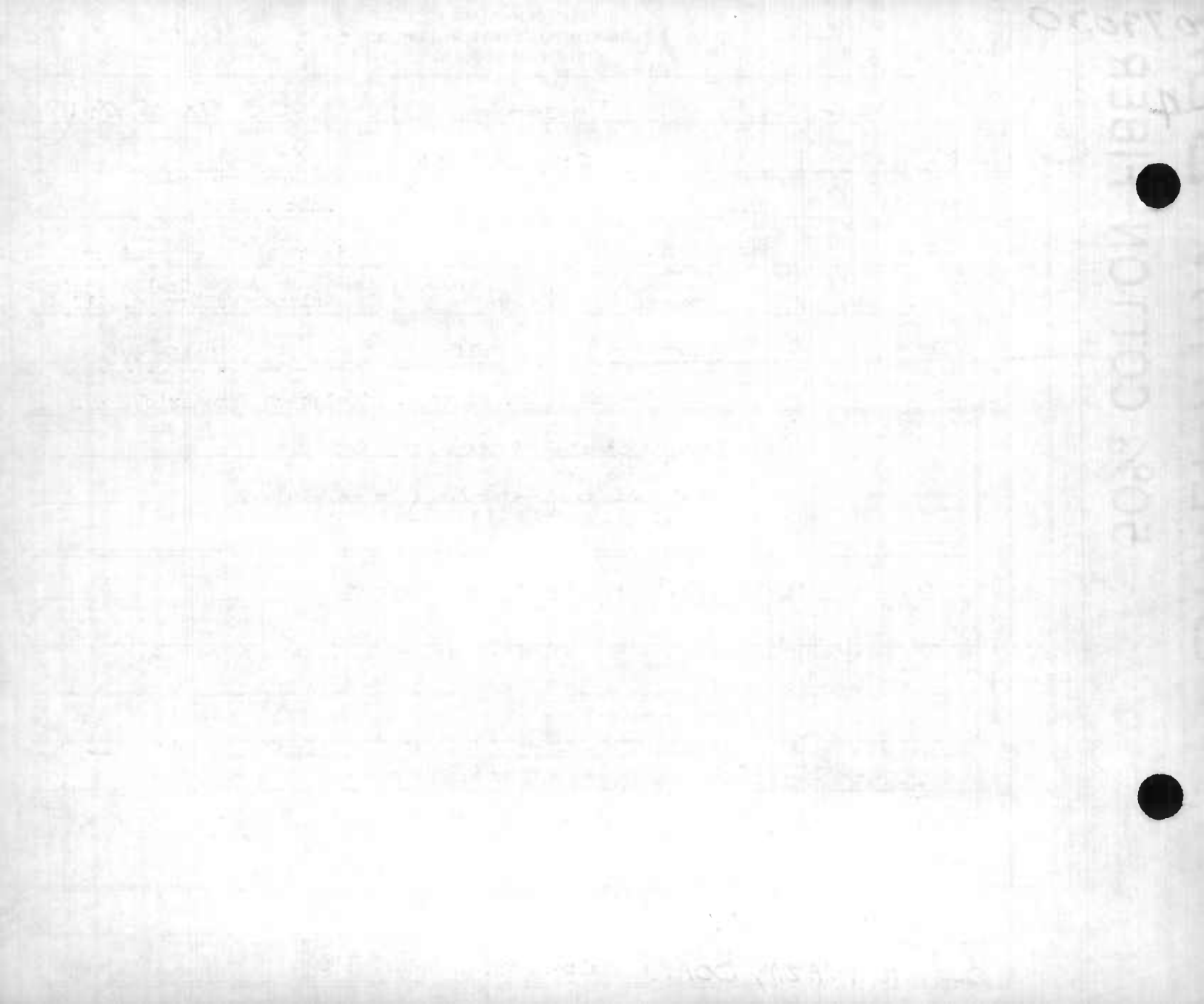
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1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
Joseph Thorning		03 08 85 09:18 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
M	W	04 25 1896	88 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Wisconsin	U.S.		Balto. City MD
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Balto.	Mercy Hosp.	Priest	Ministry
13a. STATE		13b. COUNTY	13c. CITY OR TOWN
Md.		Towson	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Cully M. Thorning		Julia T. Hallosey	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS	
No	219-44-3026	Dr. Henry T. Eigelsbach 13 W. 13th St. Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory / cerebral arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>possible pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>massive upper gastrointestinal bleed</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>massive upper gastrointestinal bleed</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that Mr. (this hospital) attended the deceased from <u>5-5</u> , 19 <u>85</u> , to <u>3-5</u> , 19 <u>85</u> , that (he)(we) last saw the deceased alive on <u>3-8</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) did not view the body after death.			
22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
Jeannine Saunders MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	3-8-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
Jeannine Saunders	Mercy Hospital		
23a. BURIAL (CREMATION) REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Removal	3/9/85		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Body to Anatomy Board		MAR 15 1985	Richard Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Their please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as high, it shows any injury, or other traumatic event, or other traumatic event, or other traumatic event, or other traumatic event.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>KATHERINE C. TIERNEY</b>			2a DATE OF DEATH MONTH DAY YEAR <b>MARCH 15, 1985</b>		2b HOUR <b>2:30 AM</b>
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>10 25 1896</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Embroidery</b>	
13a STATE <b>Maryland</b>			13b COUNTY	13c CITY OR TOWN <b>Baltimore</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Raith</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Theresa Pfleegle</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-05-6507</b>		17 INFORMANT ADDRESS <b>Cathy O'Neill 3450 W. Caton Ave. 21229</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe congestive failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>sepsis, pneumonia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>3-9-85</u> , 19____, to <u>3-15-85</u> , 19____, that (I) (we) last saw the deceased alive on <u>3-15-85</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Philip M. ...</i>		DEGREE <b>MD</b>		22c DATE SIGNED <b>3-15-85</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Philip M. ... MD</b>		22e ADDRESS <b>ST. AGNES HOSPITAL, Baltimore MD 21229</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>3/18/85</b>	23c NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>		ADDRESS <b>4107 Wilkens Ave.</b>		25a DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MARCH 17, 1900

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the matter of the purchase of the land for the proposed road from the State of New York.

I am sorry to hear that you are unable to obtain the necessary information from the State of New York. I will endeavor to obtain the same for you as soon as possible.

I am, Sir, very respectfully,  
Yours,  
J. B. [Name]

085048

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSIE MAE TILLERY			2a. DATE OF DEATH MONTH DAY YEAR 3 18 85		2b. HOUR 6:20 P.M.
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 30 33		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	# UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY					

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1359 Gorsuch Ave, 21218	
14. FATHER'S NAME FIRST MIDDLE LAST Wade Tillery		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia Moore			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 244-48-6089	17. INFORMANT ADDRESS Edward L. Tillery 2205 Fleetwood Ave.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC PULMONARY ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>GASTRIC OUTLET OBSTRUCTION</u>		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>GASTRIC CARCINOMA</u>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

19a. DATE OF OPERATION 12/14/84	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastric Outlet Obstruction	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (this hospital) attended the deceased from <u>12/8</u> <u>1984</u> to <u>3/18</u> <u>1985</u> , that (I) <u>last</u> saw the deceased alive on <u>3/18</u> <u>1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>G.K. HATOUN</u> M.D. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 3/18/85 6:25 PM
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.K. HATOUN MD		22e. ADDRESS UNION MEMORIAL HOSP- BALTIMORE, MD. 21218	

23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 3/22/85	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	23d. LOCATION BALTIMORE, COUNTY Md. STATE
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24. FUNERAL DIRECTOR Wm C March F/H Inc. 1101 E North Avenue	25a. DATE RECEIVED BY REGISTRAR MAR 20 1985	25b. REGISTRAR'S SIGNATURE <u>Randall</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

08170

1- FOR  
STATE  
REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Titus Tillman</b>			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 3-14 19 85			2b. HOUR 2:50 a.m.		
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR 3 21 02	6. AGE (IN YEARS) LAST BIRTHDAY 82 YRS.	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 3-14 19 85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1721 Brentwood Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1721 Brentwood Avenue</b>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Unknown</b>		16b. SOCIAL SECURITY NO. <b>247-32-0396</b>		17. INFORMANT ADDRESS <b>Bernice Richardson 1721 Brentwood</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>3-14-85</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>		ADDRESS <b>111 Penn St., Balto., Md. 21201</b>						
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3/18/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eastview Memorial Pk.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H Inc. 1101 E North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 15 1985</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

08171

1. DECEASED NAME (TYPE OR PRINT)		FIRST DWIGHT		MIDDLE TINGLER		LAST TINGLER		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 3		DAY 21		YEAR 1985		2b. HOUR 11:56 P.M.							
3 SEX M		4 RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6/28/45		6. AGE (IN YEARS) LAST BIRTHDAY 39 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 21 1985		24 HOUR 11:56 P.M.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD											
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3012 Loch Raven Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed				12b. KIND OF BUSINESS OR INDUSTRY Roofer											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE MD				13b. COUNTY				13c. CITY OR TOWN Balto.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 3012 Loch Raven Blvd, 21218							
14. FATHER'S NAME FIRST MIDDLE LAST Claude A. Tingler						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gretta Kemper																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 220 42 9802						17. INFORMANT ADDRESS Gretta Tingler, Balto., MD											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head (unspecified weapon)</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR <del>XXX</del> MONTH DAY YEAR P.M. 3-21- 19 85						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted.											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home						21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3012 Loch Raven Rd., Balto. County Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>Ann M. Dixon</i>						M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 3-22-85											
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.						ADDRESS 111 Penn St., Balto., Md. 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/25/85				23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial				23d. LOCATION CITY OR TOWN COUNTY STATE Balto. County MD											
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212												25a. DATE REC'D. BY REGISTRAR MAR 26 1985						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH85 08172  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Robert Torrence		Male		Black	
5. DATE OF BIRTH		6. AGE		7a. BIRTHPLACE	
4-15-85		68 YRS.		N.C.	
7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION	
Baltimore		Provident Hospital		Trackman	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE		13b. COUNTY	
B&O R.R.		(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		Baltimore	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2103 N. Hilton ST 21216	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Robert Torrence		Minnie Torrence		NO (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
243-05-0048		Dorothy Torrence		2103 N. Hilton St. (16)	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction					
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Severe Chronic lung disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
AT WORK AT WORK					
22a. I certify that (I) (this hospital) attended the deceased from Oct 1, 1981, to 3/6, 1985, that (I) (we) lost saw the deceased alive on 3/6, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Kwang H. Lee		M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		3/13/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Kwang H. Lee		100 N Broadway Baltimore MD 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		3-16-85		Church Cemetery	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Gastonia N.C.		MAR 14 1985		John Davidson-Randall	
24. FUNERAL DIRECTOR					
NAME Chas. A. Rice FSPA 1300 Eutaw Pl. ADDRESS					

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*[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Verlin C. Trefren</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3 26 85</b>		2b. HOUR <b>9 43</b> a.m.	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 20 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Operating Engineer-Federal Gov't</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Dundalk</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Not Known</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Not Known</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 395-12-4180</b>		17. INFORMANT <b>John Trefren</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Probable Sepsis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>hours</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>March 25, 19 85</b> , to <b>March 26, 19 85</b> , that (I) (we) last saw the deceased alive on <b>March 26, 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Richard Goldman</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/26/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard Goldman</b>		22e. ADDRESS <b>4940 Eastern Ave Balt MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3/29/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>		ADDRESS <b>7922 Wise Avenue Dundalk, Maryland 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 28 1985</b>	
		25b. REGISTRAR'S SIGNATURE <b>Lia Davidson-Rendall</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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Wm. C. Taylor  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 5 0 8 1 7 4

1 - FOR  
STATE  
REGISTRAR

EDITH EVANS TROTTER CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edith Trotter</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03/25/85</b>			2b. HOUR <b>9:20 AM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 02 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>			
12b. BALTIMORE BOARD OF ED.		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Middle River</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1808 Wilson Pt. Rd. 21220</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles S. Evans</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith F. Swindel</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>5 77-05-9462</b>		17. INFORMANT ADDRESS <b>Katharine Trotter, Daughter</b>				Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Septic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Transitional Cell Carcinoma; Severe COPD</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Transitional Cell Carcinoma; Severe COPD</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED <input type="checkbox"/> WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/18</b> , 19 <b>85</b> , to <b>3/25</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/25</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jorge F. Gonzalez</b> MD				22c. DATE SIGNED <b>3/25/85</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jorge F. Gonzalez</b>				22e. ADDRESS <b>Sinai Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/28/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>			
24. FUNERAL DIRECTOR <b>Prudzinski Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Jorge F. Gonzalez</b>			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMM - 16 50M 4/83  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEAOTA A. TRUXAL			2a. DATE OF DEATH MONTH DAY YEAR 03 2 85			2b. HOUR 8:30 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 4, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Chauncey F. Ackerman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Dugan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 181 18 7263		17. INFORMANT Sally Truxal,			ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESP ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MIN YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>ELECTROLYTE ABNORMALITIES</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his husband) attended the deceased from 2/25, 19 85, to 3/2, 19 85, that (I) (we) last saw the deceased alive on 3/2, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE C. E. Hughes						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. C.E. Hughes, MD						22e. ADDRESS Sinai Hospital, Balto., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3/4/85		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD		
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212						25a. DATE REC'D. BY REGISTRAR MAR 4 1985			
25b. REGISTRAR'S SIGNATURE The Registrar									

MEDICAL CERTIFICATION

5/2/77

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**Abstract**

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Dr. C.E. Hughes, MD

St. Joseph Hospital, Toledo, Ohio

noir et blanc.

Green Mount

4. 07/8/9

Howe & Sons Co.

State of New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth A. Turner</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/13/85</b>			2b. HOUR <b>3:25 PM</b>			
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 29 29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balt. City, MD.</b>			
10 CITY OR TOWN OF DEATH <b>Balt.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ. of Md.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>725 George St #4B 21201</b>		
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balt</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>James A. Wilmer</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Conger</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>215-26-4607</b>		17 INFORMANT ADDRESS <b>Anna A. Chalk 1831 E. Lafayette Ave.</b>		
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Brain Herniation</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Left Subdural Hematoma.</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>On Coumadin therapy.</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/12</b> , 19 <b>85</b> to <b>3/13</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/13</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Michael Econs MD</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/13/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael Econs MD</b>						22e. ADDRESS <b>Univ of Md. Hosp.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/18/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>		
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 E. North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 15 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara Randall</b>	

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Henry H. Turner</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 03 85</b>			2b. HOUR <b>6:45 A M</b>			
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>03 18 94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chemist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Muth Brothers</b>	
13a. STATE <b>MD</b>			13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>104 Winters Ave. Catonsville, Maryland 21228</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Turner</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Moore</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW I</b>			
16b. SOCIAL SECURITY NO. <b>215-09-2387 A</b>			17. INFORMANT ADDRESS <b>Mr. Matthew W. Turner Baltimore, Md. 21228</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>airway obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Chronic Renal Failure</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/2</b> , 19 <b>85</b> , to <b>3/3</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/3</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>George F. Gonzalez</b> MD				DEGREE <b>MD</b>			22c. DATE SIGNED <b>3/3/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George F. Gonzalez</b>				22e. ADDRESS <b>Sinai Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/7/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Star Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL HOME <b>Nutter &amp; Sons</b> NAME <b>Funeral Home Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 6 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendall</b>			

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

62-1116



Maryland

Baltimore

Annie

Turner

David

Yes

No

215-10-38 A pr. Mother L. Turner Baltimore, Md. 21228

332 Melvin Avenue  
Baltimore, Md. 21228

Moore

Christ

Catonville, Maryland 21228

104 Clinton Ave.  
Baltimore, Md. 21228

General Home Inc. Baltimore, Maryland 21216  
Hutter & Sons 2501 G. V. H. Bldg. Baltimore  
Burl J 3/7/28 Western Star Cemetery

Baltimore, Maryland



098024

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 7 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY</b> <i>Mary</i>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 29 85</b>			2b. HOUR <b>2204 M</b>		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>8 24 17</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>67</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Med. Ctr</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House wife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>			13. STREET ADDRESS / ZIP CODE <b>7 Bayside Dr. Balto., Md 21222</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Karl Milburn</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Alice Anderson</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		
16b. SOCIAL SECURITY NO. <b>219-30-4416</b>			17. INFORMANT ADDRESS <b>Laurence L. Tyson Same as 13c</b>			13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13b. STATE <b>Maryland</b>			13c. CITY OR TOWN <b>Balto.</b>			13d. CITY OR TOWN <b>Dundalk</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*hypoxemia*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*1 day*

DUE TO, OR AS A CONSEQUENCE OF

(b) *possible pulmonary emboli*

DUE TO, OR AS A CONSEQUENCE OF

(c) *fractured @ leg*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

*Atherosclerotic heart disease*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> , 19 <u>85</u> , to <u>3/29</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/29</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>SJ Kithen</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3-29-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SJ Kithen</b>				22e. ADDRESS <b>Francis Scott Key medical Ctr</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-1-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck Funeral Home inc 7922 Wise Ave Balto Md 21222</b>				25a. DATE REC'D BY REGISTRAR <b>APR 2 - 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Car Anderson-Randall</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as work, 18 hours after death, the medical examiner will be notified.

150400

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To

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 7 9

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAUL JOSEPH UHLMAN, SR.			2a. DATE OF DEATH MONTH DAY YEAR 3 26 85			2b. HOUR 2:20 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 5 09		6. AGE (IN YEARS LAST BIRTHDAY) 75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Storeroom-Clerk		12b. KIND OF BUSINESS OR INDUSTRY Kaiser Aluminum	
13a. STATE Maryland				13b. COUNTY Prince Georges		13c. CITY OR TOWN Laurel	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Mary O. Uhlman 12401 Silverbirch Lane 20708			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>See his</u> <u>See - yes</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerosis, CVA to abdomen, Congestive Heart Failure, Periph.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/17</u> , 19 <u>85</u> , to <u>3/26</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/26</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Veneranda G. Barnes</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/26/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>VENERANDA G. BARNES</u>		22e. ADDRESS <u>NORTH CHARLES GEN. HOSP.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3/29/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</u>				25a. DATE REC'D. BY REGISTRAR <u>MAR 27 1985</u>		25b. REGISTRAR'S SIGNATURE <u>W. W. WARDEN</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



100% COTTON  
CHILDREN'S